

DHMH-16 Rev 1/89

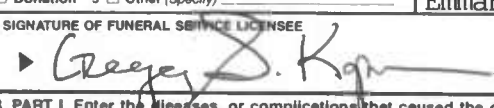
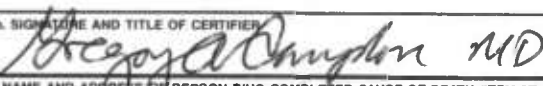
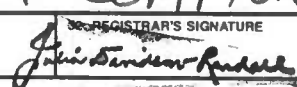
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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00002

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Ann Buckley | | | | 2. DATE OF DEATH MONTH DAY YEAR January 1, 1994 | | 3. TIME OF DEATH 1:45 a m | |
| 4. SOCIAL SECURITY NUMBER 129-09-2976 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03/31/1909 | |
| 9a. FACILITY NAME (If not institution, give street and number) Golden Oaks Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Laurel | | 9c. COUNTY OF DEATH Prince Georges | |
| 10a. STATE Maryland | | | | 10b. COUNTY Howard | | 10c. CITY, TOWN OR LOCATION Laurel | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 9260 Old Scaggsville Rd. | | | | 10f. ZIP CODE 20723 | | 10g. CITIZEN OF WHAT COUNTRY? Ireland | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeping | | 16b. KIND OF BUSINESS/INDUSTRY Bank | | | |
| 17. FATHER'S NAME (First, Middle, Last) Mark McSweeney | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen Sugrue | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret M. Lubner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9260 Old Scaggsville Rd. Laurel, Md. 20723 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Emmanuel Cemetery | | DATE 1/4 | | 20c. LOCATION — City or Town, State Scaggsville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A. 313 talbott Ave. Laurel, Md. 20707 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION a. DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIA BETES | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  MD | | | | 29c. LICENSE NUMBER DZ4942 | | 29d. DATE SIGNED (Month, Day, Year) 1/1/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORY A. COMPTON MD 8317 Cherry Ln Laurel MD 20707 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 03 1994 | | | | REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THE DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE VITAL RECORDS DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

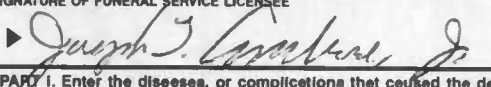


TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00003

| | | | | | |
|--|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) STEPHANIE A. BUTTS | | | 2. DATE OF DEATH MONTH JANUARY DAY 2 YEAR 1994 | | 3. TIME OF DEATH 12:25 A M |
| 4. SOCIAL SECURITY NUMBER 214-31-4607 | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 3 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 11/26/90 | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE MD | 10b. COUNTY Baltimore | 10c. CITY, TOWN OR LOCATION Lansdowne | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 293 Hazel Avenue | | 10f. ZIP CODE 21227 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) none | | 16b. KIND OF BUSINESS/INDUSTRY none | |
| 17. FATHER'S NAME (First, Middle, Last) Robert A. Butts | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth A. Myers | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr/Mrs Robert A. Butts | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 293 Hazel Avenue, Lansdowne, Maryland 21227 | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 1/5 | | 20c. LOCATION — City or Town, State Dorsey, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | 22. NAME AND ADDRESS OF FACILITY Ambrose F.H. of Lansdowne 2719 Hammonds Fy. Rd. Lansdowne, MD 21227 | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTISYSTEM ORGAN FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. FAMILIAL ERYTHROPHAGOCYTIC SYNDROME DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | Approximate Interval Between Onset and Death 48 HRS 3 yr. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) 1.2.94 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHNS HOPKINS HOSPITAL - PEDIATRIC ICU | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 03 1994 | | 32. REGISTRAR'S SIGNATURE  | | | |

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00004 | | | |
|--|--|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) William K. Himmelheber, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR 01/01/94 | | 3. TIME OF DEATH 1517 M | | | |
| 4. SOCIAL SECURITY NUMBER 218-62-0166 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/04/54 | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Catonsville | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| 10e. STREET AND NUMBER 1306 N. Rolling Road | | | | 10f. ZIP CODE 21228 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Quality Control Inspector | | 16b. KIND OF BUSINESS/INDUSTRY Electronics Manufacturing | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Kenneth Himmelheber, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Marie Smith | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy M. Himmelheber | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 N. Rolling Road Catonsville, MD 21228 | | | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 01/03 | | 20c. LOCATION — City or Town, State Baltimore, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute pulmonary edema + Shock DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. Cirrhosis of the liver + hepatic failure DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 7 Homicide | | | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John Hyatt | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 01/01/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 19 WALKER AVE. Suite 302 - Pikesville - 21208 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 01/JAN 03 1994 | | | | 32. REGISTRAR'S SIGNATURE John H. ... | | | | | |

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NEW YORK (B) (C) (D)

NEW YORK (B) (C) (D)

NEW YORK (B) (C) (D)

NEW YORK (B) (C) (D)

94 00005

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elizabeth R. Hann | | | | 2. DATE OF DEATH MONTH Jan. DAY 02 YEAR 1994 | | 3. TIME OF DEATH 11A M | |
| 4. SOCIAL SECURITY NUMBER 220-20-0427 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 02/14/29 | |
| 8a. FACILITY NAME (If not institution, give street and number) Joseph Richey Hospice, Inc. | | | | 8b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 8c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2818 Illinois Avenue | | | | 10f. ZIP CODE 21227 | | 10g. CITIZEN OF WHAT COUNTRY? usa | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES none | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: no | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) bookkeeper | | 16b. KIND OF BUSINESS/INDUSTRY mfg. | |
| 17. FATHER'S NAME (First, Middle, Last) Louis J. Hoehl, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Caroline Evelyn Nizer | | | |
| 19a. INFORMANT'S NAME (Type/Print) William E. Hann | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2818 Illinois Avenue Baltimore Md 21227 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Cedar Hill Cemetery | | DATE 1/4 | | 20c. LOCATION — City or Town, State Brooklyn Park, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph J. Ambrose Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home 1328 Sulphur Spring Road, Arbutus, Md | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ca of BREAST c METS TO BONE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death 1-2 yrs |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael H. Hayes, MD</i> | | | | 29c. LICENSE NUMBER D02290 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 03 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Rodriguez</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00006

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Catherine L Herron</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>1</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>1715P</i> M | | | |
| 4. SOCIAL SECURITY NUMBER <i>215-01-7756</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>87</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>2/1/06</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>MD</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Charlestown Care Ctr</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Catonsville</i> | | | 9c. COUNTY OF DEATH <i>Baltimore</i> | | |
| 10a. STATE <i>Md</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER <i>1406 Rosecroft Terrace</i> | | | | 10f. ZIP CODE <i>21229</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>white</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Clerk</i> | | 15b. KIND OF BUSINESS/INDUSTRY <i>Sales</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>James O. Hines</i> | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Kathryn Monaghan</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Joseph Herron</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>230 Deep Dale Drive, Timonium, Md. 21093</i> | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>New Cathedral Cemetery</i> | | DATE <i>1/4</i> | | 20c. LOCATION — City or Town, State <i>Baltimore, Md.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John S. [Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Sterling Ashton Funeral Home 736 Edmondson Avenue, Balto, Md. 21228</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Septic Shock Negative Septicemia / Bacteremia</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Septic Shock</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>4 days</i> | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | | | 29c. LICENSE NUMBER <i>D43375</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | 29d. DATE SIGNED (Month, Day, Year) <i>1/2/94</i> | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 03 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>John Benjamin Randall</i> | | | | | | | |

94 00007

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>WARREN RUCKER JOYCE, SR.</u> | | | | 2. DATE OF DEATH MONTH <u>1</u> DAY <u>1</u> YEAR <u>94</u> | | 3. TIME OF DEATH <u>11:30 AM</u> | |
| 4. SOCIAL SECURITY NUMBER <u>224-34-9978</u> | | 5. SEX <u>1</u> M <u>2</u> F | | 6. AGE (In yrs. last birthday) <u>63</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>APRIL 24, 1930</u> | |
| 8. BIRTHPLACE (State or Foreign Country) <u>VIRGINIA</u> | | | | 9a. FACILITY NAME (If not institution, give street and number) <u>ST. AGNES HOSPITAL</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u> | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE <u>MARYLAND</u> | | | |
| 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u> | | | |
| 10d. INSIDE CITY LIMITS? <u>X</u> YES <u>2</u> NO | | | | 10e. STREET AND NUMBER <u>2313 WASHINGTON BOULEVARD</u> | | | |
| 10f. ZIP CODE <u>21230</u> | | | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 11. MARITAL STATUS <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> YES <u>2</u> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> YES <u>2</u> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <u>7TH GRADE</u> College (1-4 or 5+) <u>SUPERVISOR</u> | | | | 16. KIND OF BUSINESS/INDUSTRY <u>FURNITURE COMPANY</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>WALFORD JOYCE</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>MATTIE WADE Lucy Mattie Wray</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>WARREN JOYCE, JR.</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2313 WASHINGTON BLVD., BALTIMORE, MD. 21230</u> | | | |
| 20a. METHOD OF DISPOSITION <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>MEADOWRIDGE MEMORIAL PARK 1/5</u> | | 20c. LOCATION — City or Town, State <u>ELKRIDGE</u> | | 22. NAME AND ADDRESS OF FACILITY <u>HUBBARD FUNERAL HOME INC.</u> <u>4107 WILKENS AVENUE-BALTIMORE, MD. 21229</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>LUNG CA</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <u>1</u> YES <u>2</u> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <u>1</u> YES <u>2</u> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <u>1</u> YES <u>2</u> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA OTHER: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? <u>1</u> YES <u>2</u> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <u>1</u> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u> | | | | 29c. LICENSE NUMBER <u>A22428528 900</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>1/1/94</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>TIMOTHY KLEPPER 900 CATON AVE, BALTIMORE, MD</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>1/1 JAN 03 1994</u> | | | | 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

DIVISION OF VITAL RECORDS P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

EXHIBIT 100-100000

100-100000

100-100000

100-100000

100-100000

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00008

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>James E. Jones</u> | | | | 2. DATE OF DEATH MONTH <u>01</u> DAY <u>01</u> YEAR <u>94</u> | | 3. TIME OF DEATH <u>1900</u> M | | | | | |
| 4. SOCIAL SECURITY NUMBER <u>217-12-3203</u> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>69</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>6/03/24</u> | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>St. Agnes Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u> | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION <u>Baltimore</u> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10a. STATE <u>Md</u> | | 10b. COUNTY | | 10e. STREET AND NUMBER <u>337 Gwynn Ave</u> | | | | 10f. ZIP CODE <u>21229</u> | | | |
| 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY <u>George J. Falter's</u> | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Jones</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Katie Jones</u> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Brenda P. Jones</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>337 Gwynn Ave Baltimore, MD 21229</u> | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Garrison Forest</u> | | DATE <u>1-6</u> | | 20c. LOCATION — City or Town, State <u>Baltimore, Md</u> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>James C. Mort...</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>James A. Mortobon & Sons</u> <u>1701 Laurens St.</u> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>LIVER CELL FAILURE + LIVER METASTASES</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>COLON CANCER</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <u>4 mths</u> <u>6 yrs.</u> | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>None</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>RESIDENT</u> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <u>1/2/94</u> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>DR BAHETHI</u> <u>ST AGNES HOSPITAL</u> <u>BALTIMORE</u> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 03 1994</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John Sander-Randall</u> | | | | | | | |

30000 42



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00009 | |
|--|--|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | |
| LEROY JACKSON, SR | | | | 01 01 94 | | | | 3:00 PM | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | |
| 213-05-0886 | | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 83 YRS. | | 6-17-10 | | S. C. | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | |
| Liberty Medical Center | | | | Baltimore | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | |
| Md | | | | Baltimore | | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 3705 Grantley Rd | | | | 21215 | | U. S. A | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE - American Indian, Black, White, etc. | | | |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12) 8th | | | | College (1-4 or 5+) | | Norwalk Trucking Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| Leonard Jackson | | | | Suzanne Sanders | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| Leroy Jackson, Jr | | | | 3705 Grantley Rd Baltimore Md 21215 | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION - City or Town, State | | | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | King Henry Park | | 11/4/94 | | Randallstown, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | |
| Gladys Wane | | | | March F.H. West 4300 Wabash Ave | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Renal Failure | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | M | | | | | |
| 28a. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| Sher A Hashmi | | | | D24648 | | 1-1-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| SHER A HASHMI 2600 LIBERTY HEIGHTS Ave 21215 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | |
| JAN 03 1994 | | | | Julia E. ... | | | | | |

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 94 00010

| | | | | | | | |
|---|--|--|--|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JUZEFA KRYSIAK | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN. 1, 1994 | | 3. TIME OF DEATH 3:05 A. M | |
| 4. SOCIAL SECURITY NUMBER 018-26-9363 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 100 YRS. | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 23, 1893 | 8. BIRTHPLACE (State or Foreign Country) LITHUANIA | | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. MARTINS HOME (LSOP) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1080 DOWNTON ROAD | | | | 10f. ZIP CODE 21227 | | 10g. CITIZEN OF WHAT COUNTRY? LITHUANIA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) UNKNOWN | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY HOMEMAKING | | | |
| 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARIA PRANCKONIS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 GAINESBORO ROAD - LAWRENCEVILLE, N.J. 08648 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) NEW CATHEDRAL CEMETERY 1/4 | | 20c. LOCATION — City or Town, State BALTIMORE | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. Thel Colman</i> | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DEMENTIA DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. Karan MD</i> | | | | 29c. LICENSE NUMBER 021649 | | 29d. DATE SIGNED (Month, Day, Year) 1-3-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. SAMBANDAN BASKARAN - 3455 WILKENS AVENUE - BALTIMORE, MD. 21229 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 03 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John B. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 000111

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Florence E. Kanatzen</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>1-1-1994</i> | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER <i>217-09-4457A</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>79</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>8-30-1914</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>2403 Hemlock Ave. 21214</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH <i>Baltimore</i> | |
| 10a. STATE <i>Md.</i> | | | | 10b. COUNTY <i>Baltimore</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER <i>2403 Hemlock Ave.</i> | | | | 10f. ZIP CODE <i>21214</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Home</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Charles Frick</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Catherine Siebert</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mr. David R. Kanatzen</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3016 Acton Rd. Balto., Md 21234</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Parkwood Cem. 1/1/94 Balto., Md</i> | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Hantley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234</i> | | | |
| 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Constrictive Heart Failure</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER <i>D32743</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/3/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 03 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LOIS B MERRITT | | 2. DATE OF DEATH MONTH DAY YEAR 01 01 94 | | 3. TIME OF DEATH 01:30 PM | |
| 4. SOCIAL SECURITY NUMBER 216-28-3767 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) April 15, 1904 | | 8. BIRTHPLACE (State or Foreign Country) Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | | 9c. COUNTY OF DEATH A.A. COUNTY | |
| 10a. STATE Md. | | 10b. COUNTY Anne Arundel Co. | | 10c. CITY, TOWN OR LOCATION Odenton | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 528 Bruce Ave | | 10f. ZIP CODE 21113 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Food Service | | 16b. KIND OF BUSINESS/INDUSTRY A.A. Co. Schools | |
| 17. FATHER'S NAME (First, Middle, Last) George Marshall | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lila Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) P. Marie Kerns | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 528 Bruce Ave. Odenton, Maryland 21113 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory | | 20c. LOCATION — City or Town, State Baltimore Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home 851 Annapolis Rd. Gambrills Md 21054 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| 24. Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER D12808 | | 29d. DATE SIGNED (Month, Day, Year) 1-2-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WU CHARLES - M.D. / 16 CRAIN HIGHWAY, SW. #306/GLEN BURNIE MARYLAND 21061 | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 03 1994 | | 32. REGISTRAR'S SIGNATURE | | | |

31000 28

WILSON

WILSON

SECTION FIVE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00013 | | | |
|--|--|---|---|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) RAIMON DEL RIO - MARCH | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 2 1994 | | | | 3. TIME OF DEATH 3:05 A | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 2 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) JUNE 7, 1991 | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH - | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE TARRAGONA | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION FLIX | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER JOAN MARAGALL #3-20- | | | | 10f. ZIP CODE 43750 | | 10g. CITIZEN OF WHAT COUNTRY? SPAIN | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: SPANISH | | 14. RACE — American Indian, Black, White, etc. Specify: - | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) - College (1-4 or 5+) - | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) LOSE LUIS DEL RIO MATEU | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIA DOLORES MARCH ROCA | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOME AS ABOVE | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CEM. 1-3-94 | | DATE BALTIMORE, MD. U.S.A. | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeffrey L. Gier LIC.# MO0677 | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF CHIMES 2325 YORK RD. TIMONUM, MD. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ventricular fibrillation a. DUE TO (OR AS A CONSEQUENCE OF): b. Congestive heart failure c. Congenital heart disease d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST e. 2 yrs | | | | | | | | Approximate interval between Onset and Death 10 minutes weeks 2 yrs | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Stephen J. Davis MD | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/2/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Hospital Pediatric ICU | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 03 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | |

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DATE 10/10/10

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 94 00014 | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>HARRY Edward</u> | | | | 2. DATE OF DEATH MONTH <u>1</u> DAY <u>11</u> YEAR <u>94</u> | | | | 3. TIME OF DEATH <u>11:50A</u> | |
| 4. SOCIAL SECURITY NUMBER <u>212 36 8785</u> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>54</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>Oct. 2, 1939</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Church Home Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u> | | | | 9c. COUNTY OF DEATH <u>N/A</u> | |
| 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>N/A</u> | | 10c. CITY, TOWN OR LOCATION <u>Baltimore City</u> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>1249 Broening Highway</u> | | | | 10f. ZIP CODE <u>21224</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (8-12)</u> | | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Stevedore</u> | | 16a. KIND OF BUSINESS/INDUSTRY <u>I.T.O.</u> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Harry E. Rehm, Sr.</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Elizabeth Smith</u> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Faye A. Rehm</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1249 Broening Highway, Baltimore, Maryland 21224</u> | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Stone Church Cemetery</u> | | DATE <u>1/6/94</u> | | 20c. LOCATION — City or Town, State <u>Mechanicsburg, Pa.</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Kathleen M. Murphy</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>John C. Miller, Inc.</u> <u>6415 Belair Road, Baltimore, Maryland 21206</u> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CANCER OF LUNG</u> DUE TO (OR AS A CONSEQUENCE OF): a. <u>CANCER OF LUNG</u> b. <u>DUE TO (OR AS A CONSEQUENCE OF):</u> c. <u>DUE TO (OR AS A CONSEQUENCE OF):</u> d. <u>DUE TO (OR AS A CONSEQUENCE OF):</u> Approximate interval Between Onset and Death <u>Months</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC LUNG DISEASE</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>A. P. Nazem M.D.</u> | | | | 29c. LICENSE NUMBER <u>D17322</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>1/11/94</u> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 03 1994</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John Benison-Randall</u> | | | | | |

1000 42

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 94 00015

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY A ROSE Mary Agnes Rose | | | | 2. DATE OF DEATH MONTH 01 DAY 01 YEAR 94 | | 3. TIME OF DEATH 0335 M | |
| 4. SOCIAL SECURITY NUMBER 214 38 4393 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 01 28 16 | |
| 8. BIRTHPLACE (State or Foreign Country) MD | | | | 9a. FACILITY NAME (If not institution, give street and number) University of Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MD. | | | |
| 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 730 South Decker Avenue | | | |
| 10f. ZIP CODE 21224 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeper | | 16b. KIND OF BUSINESS/INDUSTRY Church | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Schrieber | | | |
| 19a. INFORMANT'S NAME (Type/Print) Laird J. Rose | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 730 S. Decker Avenue Balto., Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cem 1-4-94 Dundalk, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 901 S. Conkling Street | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Liver metastases DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Stage four ovarian carcinoma DUE TO (OR AS A CONSEQUENCE OF): c. of low malignant potential DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death 12 days 24 years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  Jubilee Brown MD | | | | 29c. LICENSE NUMBER D38972 | | 29d. DATE SIGNED (Month, Day, Year) 1-1-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JUBILEE BROWN MD UNIV MD MED CTR 225 GREENE ST BALTIMORE MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1-1 JAN 03 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31000 10

Handwritten signature

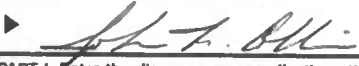
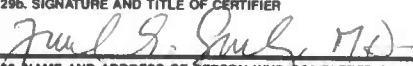
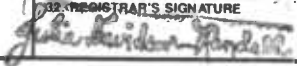
APR 6 9 1941



94 00016

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Margaret S. Ruth | | | | 2. DATE OF DEATH MONTH JAN DAY 2 YEAR 1994 | | 3. TIME OF DEATH 4:25 AM | |
| 4. SOCIAL SECURITY NUMBER 216-03-6690 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 91 YRS. | 7. DATE OF BIRTH (Month, Day, Year) Jan. 24, 1902 | | 8. BIRTHPLACE (State or Foreign Country) Hungary | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH --- | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 9603 Dundawan Road | | | | 10f. ZIP CODE 21236 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Saleswoman | | 16b. KIND OF BUSINESS/INDUSTRY Whitney's Dept. Store | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Barger | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Suzana Jacob | | | |
| 19a. INFORMANT'S NAME (Type/Print) Virginia R. Simpson (Step-dgthr) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9603 Dundawan Road, Baltimore, Md. 21236 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenwood Memorial Park | | DATE 1/5 | 20c. LOCATION — City or Town, State San Diego, California | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Road, Baltimore, Md. 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death 12 days |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) NA | | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) JAN 2 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FADI SABA, MD 6101 LOCH RAVEN BLVD. BALTO, MD 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 03 1994 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate is to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00017

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Julia L Smith</i> JULIA LOUISE SMITH | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>1</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>3:20 P.M.</i> |
| 4. SOCIAL SECURITY NUMBER <i>174-24-8405</i> | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>63</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year) JUNE 4, 1930 | 8. BIRTHPLACE (State or Foreign Country) RENTON, PA | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 455 LAMBERT COURT | | | 10f. ZIP CODE 21227 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10TH GRADE</i> College (1-4 or 5+) <i>Colege (1-4 or 5+)</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY HOMEMAKING | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE KLOBUCHIR | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA MAE BRINK | | |
| 19a. INFORMANT'S NAME (Type/Print) DIANE BESSLING | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 SCOTT STREET - BALTIMORE, MD. 21230 | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY <i>1/5</i> | | 20c. LOCATION — City or Town, State BALTIMORE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jim [Signature]</i> | | 22. NAME AND ADDRESS OF FACILITY HUBBARD F.H. BARTO MD 21229 4107 WILKENS AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Septic Shock</i> b. <i>2° Metabolic Acidosis</i> c. <i>2° Bowel Ischemia</i> d. <i>Hypoperfusion</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | Approximate Interval Between Onset and Death <i>1-2 days</i> <i>1-2 days</i> <i>1-2 days</i> <i>2 days</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute Tubular Necrosis</i> <i>Spinal Cord Ischemia</i> <i>Resp. Failure</i> | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) <i>N/A</i> | | 28b. TIME OF INJURY <i>M</i> | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jaqueline Royce DO.</i> | | | 29c. LICENSE NUMBER <i>DEA AT 2438946</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/1/93</i> |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Union Memorial Hosp.</i> | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 03 1994 | | 32. REGISTRAR'S SIGNATURE <i>John [Signature]</i> | | | |

11027 48

CONFIDENTIAL

CONFIDENTIAL

94 00018

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) EDNA STELLA ARTHUR | | | | 2. DATE OF DEATH MONTH DAY YEAR January 2, 1994 | | 3. TIME OF DEATH 12:55 P M | |
| 4. SOCIAL SECURITY NUMBER 216-46-9894 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 98 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 14, 1895 | |
| 9a. FACILITY NAME (If not institution, give street and number) Manor Care - Ruxton Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Ruxton | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Parkville | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2510 Wildpark Ave. | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) John E. Salter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eliza Jamart | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charles D. Cheney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 Arabian Dr., Finksburg, MD 21048 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory | | 20c. LOCATION — City or Town, State 1/4/94 Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. George White</i> | | | | 22. NAME AND ADDRESS OF FACILITY ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD DUE TO (OR AS A CONSEQUENCE OF): b. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Carl Sperling M.D.</i> | | 29c. LICENSE NUMBER D28987 | |
| 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CARL SPERLING M.D. 5601 LOCH RAVEN BLVD 21239 | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Rodriguez</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

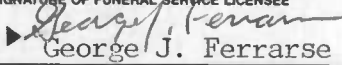
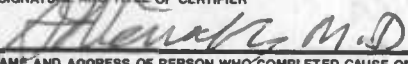
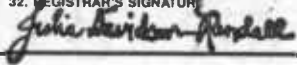
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00019

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HILDEGARDE ALONEA ARNOLD | | | | 2. DATE OF DEATH MONTH DAY YEAR January 2, 1994 | | 3. TIME OF DEATH 10:20 A. M | |
| 4. SOCIAL SECURITY NUMBER 214-26-8229 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 95 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 5, 1898 | |
| 8. BIRTHPLACE (State or Foreign Country) Texas | | | | 9a. FACILITY NAME (If not institution, give street and number) Presbyterian Home of Maryland | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Towson | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 400 Georgia Court | |
| 10f. ZIP CODE 21204 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Telephone Operator | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Telephone Operator | | 16b. KIND OF BUSINESS/INDUSTRY Baltimore Gas & Electric Co. | |
| 17. FATHER'S NAME (First, Middle, Last) Adolph G. Thiel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hannah E. Schmidt | | | |
| 19a. INFORMANT'S NAME (Type/Print) Llewellyn Arnold | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2537 Marbourne Ave. Baltimore, Maryland 21230 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park Cemetery 1-5 | | 20c. LOCATION — City or Town, State Woodlawn, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  George J. Ferrarse | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. ASCVD DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death 6 weeks years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  S.J. Veneble, M.D. | | | | 29c. LICENSE NUMBER D11026 | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S.J. Veneble, M.D. 610 Wilton Road | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

NO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21000 #2

RECEIVED

RECEIVED

ITEM: 17. PER F.H. FILM G-707 1/5/94 t.t
ITEMS: 1. 10e, 10f, PER F.H. FILM G-707 1/4/94 t.t

94 00020

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|-----------------------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>John R Bryant JR.</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>2</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>1935 PM</i> | | | |
| 4. SOCIAL SECURITY NUMBER <i>432-80-6774</i> | | 5. SEX <i>1 M 2 F</i> | 6. AGE (In yrs. last birthday) <i>47 YRS.</i> | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) <i>9/18/46</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Mercy Medical Center</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH <i>n/a</i> | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE <i>MD</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? <i>1 YES 2 NO</i> | | | |
| 10e. STREET AND NUMBER <i>250 S. PRESIDENT STREET</i> <i>250 S Preston Street</i> | | | | 10f. ZIP CODE <i>21201</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i> | | | |
| 11. MARITAL STATUS <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i> | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1 YES 2 NO</i> IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 YES 2 NO</i> | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>12th</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>UNEMPLOYED</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>n/a</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>JOHN R. BRYANT SR.</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>CATHERINE WILLIAMS</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>JOHN R. BRYANT III</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>600 COLUMBUS AVE., apt. 11k, NEW YORK, NY 10025</i> | | | | | |
| 20a. METHOD OF DISPOSITION <i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i> | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>HAVEN OF REST CEMETERY</i> | | DATE | | 20c. LOCATION — City or Town, State <i>LITTLE ROCK, ARKANSAS</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>WM. C. MARCH FH.- 1101 E. NORTH AVENUE</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i> | | | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1 YES 2 NO</i> | | | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> OTHER: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i> | | | | | |
| 27. MANNER OF DEATH <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</i> | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <i>1 YES 2 NO</i> | | | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <i>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> <i>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christ Miller MD</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Christopher P Chambers MD 301 St Paul Pl Balto MD</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 04 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is missing, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00021

| | | | | | | | | | | | | | |
|--|--|--|---|---|--|--|---|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LEONARD P. BAKER | | | | 2. DATE OF DEATH MONTH DAY YEAR 1 - 2 - 1994 | | 3. TIME OF DEATH 2:55 a.m. | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-07-1252 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-26-1911 | | 8. BIRTHPLACE (State or Foreign Country) MD. | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 830 W. 40TH ST. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO. | | | 9c. COUNTY OF DEATH | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTO. | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | |
| 10e. STREET AND NUMBER 830 W. 40TH ST | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LAWYER | | | 15b. KIND OF BUSINESS/INDUSTRY LAW | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) LEONARD P BAKER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FLORENCE CLARK | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARGARET B. BAKER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 W. 40TH ST. APT. 609 BALTO., MD 21211 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) (NICHE) ST. DAVIDS CH. 1/5 | | DATE BALTO., MD. | | 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William R. Davis III</i> | | | | 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Multi infarct Dementia b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 weeks 3 yrs | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregory Walker</i> | | | | | | | | 29c. LICENSE NUMBER D25662 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORY WALKER M.D. 201 E. UNIV. PKWY. BALTO., MD. | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Rodriguez</i> | | | | | | | | | |

1884



John H. Brown

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00022

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elvira Marie Behrman | | | | 2. DATE OF DEATH MONTH DAY YEAR January 3 1994 | | 3. TIME OF DEATH 8:30 a.m. | |
| 4. SOCIAL SECURITY NUMBER 217-74-7553 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/30/1908 | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3804 Forrester Ave. | | | | 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yr's College (1-4 or 5+) Homemaker | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Alfred Ruwaldt | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alvina Ilausman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Paul C. Behrman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 839 Killingworth, Conn. 06419 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood 1/6/94 | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul L. Hartsock, Jr. <i>Paul L. Hartsock, Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Carcinoma — probably Ovarian Primary Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ADN | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. J. J. [Signature]</i> | | | | 29c. LICENSE NUMBER D40480 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Fernando Ferro, M.D. 5810 Belair Road Baltimore, Maryland 21206 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Rodale</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00023

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Carolyn Holland, (MN) BETTY</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>1</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>933 A M</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>214-38-3693</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>50</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>10/3/37</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>MD</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Mercy Medical Center</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i> | | | | 9c. COUNTY OF DEATH <i>MD</i> | | | |
| 10a. STATE <i>MD</i> | | | | 10b. COUNTY <i>BALTIMORE</i> | | | | 10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>1746 HOMESTEAD ST.</i> | | | | 10f. ZIP CODE <i>21218</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>UNEMPLOYED</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>ARTHUR DAVIDSON</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>THERODOSIA HOLLAND</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>VANESSA BRANDON</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1101 HOLLEN R. BALTO, MD 21239</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>BALTIMORE CEMETERY</i> | | | | 20c. LOCATION — City or Town, State <i>1/6 BALTIMORE, MD</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>BETTS FUNERAL HOME</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>1129 N. CAROLINE ST. BALTIMORE, MARYLAND 21213</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Acute myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Juan D. Montoya M.D. Surgical Resident</i> | | | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>1/1/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JUAN D. MONTOYA M.D. University of Maryland Hospital</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 04 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | | | |

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00024

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Roosevelt Boatwright</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>1</i> YEAR <i>94</i> | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER <i>248-68-0234</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>50</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>6-8-43</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>712 BELGIAN AVE</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTO.</i> | | 9c. COUNTY OF DEATH <i>SC</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>md.</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>BALTO.</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>712 BELGIAN AVE.</i> | | | | 10f. ZIP CODE <i>21212</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (<i>0-12</i>) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>UNEMPLOYED</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>WILLIAM BOATWRIGHT</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ESTHER HOWARD</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>EVA BETHEA</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>501 E. PRESTON ST #418 Balto, Md. 21202</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MT. ZION CEME</i> | | 20c. LOCATION — City or Town, State <i>1/6 LANDSDOWNE, MD</i> | | 20d. DATE <i>1/3/94</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Betts Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>BALTIMORE, MARYLAND 21213 1129 N. CAROLINE ST.</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | <i>Stroke (clonk)</i> | | | | Approximate interval Between Onset and Death <i>10 years</i> | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | <i>Chronic anemia</i> | | | | <i>2 months</i> | |
| | | | | | | | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER <i>039102</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/3/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SAC-UNA YAK MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 04 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00025

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Marian Barron | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 01 94 | | 3. TIME OF DEATH 10:15 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 120-32-4111 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 16, 1908 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Fairhaven Life Care Community | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Sykesville | | | | 9c. COUNTY OF DEATH Carroll County | | | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll County | | 10c. CITY, TOWN OR LOCATION Sykesville | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 7200 Third Avenue | | | | 10f. ZIP CODE 21784 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse | | | | 18b. KIND OF BUSINESS/INDUSTRY Health Care | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Hampton Ferguson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) M. Florence Helker | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Lesley B. Rogers | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Watergate Court Silver Spring, MD 20905 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Union Cemetery Weatherly, PA 1-5-93 | | | | 20c. LOCATION — City or Town, State Weatherly, Pennsylvania | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian S. Haight | | | | 22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER E. Schenoff MD | | | | 29c. LICENSE NUMBER D02557 | | 29d. DATE SIGNED (Month, Day, Year) 1-2-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. Schenoff MD 1247 Liberty Rd Eldersburg Md 21784 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE John D. Anderson | | | | | | | |

94-0005-510
L.R.B.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00026

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BURTON LEWIS BELLINGER | | | | 2. DATE OF DEATH MONTH 01 DAY 01 YEAR 1994 | | 3. TIME OF DEATH 11:50A M | | | |
| 4. SOCIAL SECURITY NUMBER 220-56-8482 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 44 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-28-1949 | | 8. BIRTHPLACE (State or Foreign Country) NEW YORK | |
| 9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL E.R. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY. | | | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION GLEN BURNIE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6426 D CENTENNIAL CIRCLE | | | | 10f. ZIP CODE 21061 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 1972-1979 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SCHOOL TEACHER | | 16b. KIND OF BUSINESS/INDUSTRY POTOMAC HIGH SCHOOL | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) LEWIS WINFIELD BELLINGER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE LENORA WORKMAN | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) DOLORES BELLINGER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6426 D. CENTENNIAL CIRCLE, GLEN BURNIE, MARYLAND 21061 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK 1993 | | 20c. LOCATION — City or Town, State GLEN BURNIE, MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert Edwards</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Coronary Artery Thrombosis</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Ron Locke MD</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/02/1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Ron Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00027 | | | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) MARY ELLEN BERKERIDGE | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 01 94 | | | | 3. TIME OF DEATH 10:00 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER 218-12-4822 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 2, 1915 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION | | | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | | | | 9c. COUNTY OF DEATH A.A. COUNTY | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION GLEN BURNIE | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 7 WOODS AVENUE | | | | 10f. ZIP CODE 21061 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: CHEROKEE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 | | College (1-4 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DIETARY SUPERVISOR | | | | 16b. KIND OF BUSINESS/INDUSTRY SPRING GROVE STATE HOSPITAL | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) DAVID EDWARD GRAY SENSIBAUGH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) AGNES ELIZABETH SPROUSE | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) ROY BERKERIDGE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7715 LOCUST GROVE ROAD, GLEN BURNIE, MARYLAND 21060 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK 1994 | | DATE 1994 | | 20c. LOCATION — City or Town, State ELKRIDGE, MARYLAND | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Adams | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. Chronic Renal Failure DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 28. PLACE OF DEATH (Check only one) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Paul Turer M.D. | | 29c. LICENSE NUMBER D21262 | | 29d. DATE SIGNED (Month, Day, Year) 11/3/93 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL TURER, M.D. / 716 MAIDEN CHOICE LANE, #20/BALTIMORE, MARYLAND 21218 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE John Sanborn Rudolph | | | | | | | | | |

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RAYMOND J. DAM | | | | 2. DATE OF DEATH MONTH 1 DAY 2 YEAR 94 | | 3. TIME OF DEATH n/a | |
| 4. SOCIAL SECURITY NUMBER 522-01-1854 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-28-13 | |
| 9a. FACILITY NAME (If not institution, give street and number) 321 CHARTER OAK AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 321 CHARTER OAK AVENUE | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 4 yrs. (GRAD.) IRON WORKER | | 16b. KIND OF BUSINESS/INDUSTRY IRON WORKER UNION | | | |
| 17. FATHER'S NAME (First, Middle, Last) JORGEN C. DAM | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) INGER JORGENSEN | | | |
| 19a. INFORMANT'S NAME (Type/Print) CHARLES C. DAM | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 CHARTER OAK AVENUE/BALTIMORE, MARYLAND 21212 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lee V. Holland</i> | |
| 22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVENUE | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lymphoma Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] MD</i> | | | | | |
| | | 29c. LICENSE NUMBER D18487 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MYO TITANI 9101 FRANKLIN SO DR, BALTO, MD 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked for item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---------------------------------|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Gary Penton Davenport Sr.</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>2</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>6:00 P.M.</i> | | | |
| 4. SOCIAL SECURITY NUMBER <i>230-88-0658</i> | | 5. SEX <i>1</i> M <i>2</i> F | | 6. AGE (by yrs. last birthday) <i>93</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>3-2-60</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Baltimore, MD.</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>St. Joseph's</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | | | 9c. COUNTY OF DEATH <i>Baltimore</i> | |
| 10a. STATE <i>MD</i> | | | | 10b. COUNTY <i>Baltimore</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore City</i> | | | |
| 10d. INSIDE CITY LIMITS? <i>1</i> YES <i>2</i> NO | | | | 10e. STREET AND NUMBER <i>4945 Edgecombe Ave</i> | | | | 10f. ZIP CODE <i>21215</i> | |
| 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 11. MARITAL STATUS <i>1</i> Never Married <i>2</i> Married <i>3</i> Widowed <i>4</i> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> YES <i>2</i> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> YES <i>2</i> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>UNKNOWN</i> College (1-4 or 5+) <i>UNKNOWN</i> | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>Direct Care Worker</i> | | | | 17. FATHER'S NAME (First, Middle, Last) <i>Robert Davenport</i> | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Madeline Rich</i> | | | | 19a. INFORMANT'S NAME (Type/Print) <i>Kamela Madanport Williams</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5308 Colchester Ave Baltimore, MD 21215</i> | |
| 20a. METHOD OF DISPOSITION <i>1</i> Burial <i>2</i> Cremation <i>3</i> Removal from State <i>4</i> Donation <i>5</i> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Joseph's Cemetery</i> | | | | 20c. LOCATION <i>2130 Woodlawn Dr. Baltimore, MD 21217</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joe Carroll</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>1712 West North Ave Baltimore MD 21217</i> | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Cryptococcal meningitis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. AIDS</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>multisystem organ failure</i> <i>AIDS nephropathy</i> | |
| 24a. WAS AN AUTOPSY PERFORMED? <i>1</i> YES <i>2</i> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1</i> YES <i>2</i> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1</i> YES <i>2</i> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA OTHER: <i>4</i> Nursing Home <i>5</i> Residence <i>6</i> Other (Specify) | | | | 27. MANNER OF DEATH <i>1</i> Natural <i>5</i> Pending Investigation <i>2</i> Accident <i>6</i> Could not be determined <i>3</i> Suicide <i>7</i> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY <i>M</i> | | | | 28c. INJURY AT WORK? <i>1</i> YES <i>2</i> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>N/A</i> | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <i>1</i> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Anthony Phum</i> | | | | 29c. LICENSE NUMBER <i>042599</i> | | | | 29d. DATE SIGNED (Month, Day, Year) <i>1/4/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Arny Compton-Phillips MD 8028 Ritchie Hwy Pasadena, MD 21122</i> | | | | 31. DATE FILED (Month, Day, Year) <i>JAN 04 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson</i> | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL HOME: This certificate must be completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00030

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) HELEN M. DAWSON | | | | 2. DATE OF DEATH MONTH 1 DAY 3 YEAR 94 | | 3. TIME OF DEATH 4:55 | | | | | |
| 4. SOCIAL SECURITY NUMBER 094-20-7637 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 22, 1907 | | 8. BIRTHPLACE (State or Foreign Country) New York | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | | 9c. COUNTY OF DEATH Baltimore | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll County | | 10c. CITY, TOWN OR LOCATION Sykesville | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 7200 Third Avenue | | | | 10f. ZIP CODE 21784 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Education | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Gates Markham Minckler | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Stinson | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. William Dulany, Attorney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 E. Main Street Westminster, MD 21157 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Service Jan. 4, 1994 Hampstead, MD | | 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian A. Haight | | | | 22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ATRIAL FIBRILLATION; DIABETES MELLITUS OLD CORONARY-VASCULAR ACCIDENT; HYPOTENSION RESPIRATORY INSUFFICIENCY | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] MD | | | | 29c. LICENSE NUMBER D19502 | | 29d. DATE SIGNED (Month, Day, Year) 1-3-94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ORLANDO B. CONNAN MD | | | | NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

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THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE
NEW YORK 17, N.Y.

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NEW YORK 17, N.Y.

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500 5TH AVENUE
NEW YORK 17, N.Y.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The physician that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00031

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Dootson James</u> JAMES D. D. DOOTSON | | | | 2. DATE OF DEATH MONTH <u>1</u> DAY <u>3</u> YEAR <u>94</u> | | 3. TIME OF DEATH <u>12 mo</u> M | |
| 4. SOCIAL SECURITY NUMBER <u>194-07-9737</u> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>77</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) | |
| 8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA | | | | 9a. FACILITY NAME (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH COLUMBIA | |
| 9c. COUNTY OF DEATH HOWARD | | | | 10a. STATE MARYLAND | | 10b. COUNTY HOWARD | |
| 10c. CITY, TOWN OR LOCATION ELLICOTT CITY | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 10114 HOBSON'S CHOICE LANE | |
| 10f. ZIP CODE 21042 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES W W II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>College</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FACTORY WORKER | | 16b. KIND OF BUSINESS/INDUSTRY FIRESTONE TIRE & RUBBER COMPANY | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM DOOTSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY CLARK | | | |
| 19a. INFORMANT'S NAME (Type/Print) DOROTHY DOOTSON (WIFE) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10114 HOBSON'S CHOICE LANE ELLICOTT CITY MARYLAND 21042 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY 01-04-94 | | 20c. LOCATION — City or Town, State CATONSVILLE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell C. Witzke</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Acute Myocardial Infarct</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>Diabetes Mellitus</u> <u>Coronary Artery Disease</u> | | | | | | Approximate Interval Between Onset and Death <u>6 days</u> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Myocardial infarct</u> <u>Coronary Artery Disease</u> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>George E. Berle</i> MD | |
| 29c. LICENSE NUMBER D10943 | | | | | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George E. Berle MD 10308 B Baltimore Rd. Pk. Ellicott City MD | | | | | | 31. DATE FILED (Month, Day, Year) JAN 04 1994 | |
| 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | | | | | |

10000 42

(F)

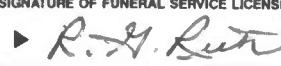
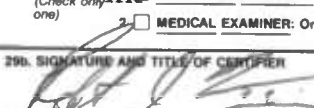

ADDITIONAL

94 00032

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY C. B. FORMAN | | | | 2. DATE OF DEATH MONTH 01 DAY 03 YEAR 94 | | 3. TIME OF DEATH 7:15 A. M. | |
| 4. SOCIAL SECURITY NUMBER 215-01-7101 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 93 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 02-26-1900 | | 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | |
| 9a. FACILITY NAME (If not institution, give street and number) MERIDIAN LONG GREEN | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 115 EAST MELROSE AVENUE | | 10f. ZIP CODE 21212 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+) SOCIAL SERVICES | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOSPITAL | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) OSCAR BRESEE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FLORENCE BOWLES | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARY F. GUY (DAUGHTER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4300 RUGBY ROAD, BALTIMORE, MARYLAND 21210 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT MAUSOLEUM 1-5 BALTO., MD. 21202 | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS 4905 YORK ROAD, BALTIMORE, MD. 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Alzheimer's dementia</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____ 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidents 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER D33897 29d. DATE SIGNED (Month, Day, Year) 01-03-94 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT J. VISSING M.D., 4300 NORTH CHARLES ST., BALTIMORE, MD. 21210 31. DATE FILED (Month, Day, Year) JAN 04 1994 32. REGISTRAR'S SIGNATURE  | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00033

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Margaret Fonte | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 01 1994 | | 3. TIME OF DEATH 3:15 PM | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 220-48-0855 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 24 1904 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Stella Maris | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | 9c. COUNTY OF DEATH Baltimore | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Balto. | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | |
| 10e. STREET AND NUMBER 6401 Loch Raven Blvd. | | | | 10f. ZIP CODE 21239 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Richard Brown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maud Baugher | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joseph Fonte | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7311 Old Harford Rd. 21234 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cemetery 1/5/94 | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert M. Kratz | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home Inc. 6500 York Rd. 21212 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. * Respiratory failure * E.O.B.A. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25a. DATE OF INJURY (Month, Day, Year) | | 25b. TIME OF INJURY M | | 25c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER 115504 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Joseph Fonte 2300 Jones Rd 21204 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 31. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | | | |

21 00033

6

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00034

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|---------------------------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HAZEL CATHERINE GUARD | | | | 2. DATE OF DEATH MONTH DAY YEAR January 3, 1994 | | 3. TIME OF DEATH 12:10 a m | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-16-5819 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 15, 1906 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Westminster Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Westminster | | | 9c. COUNTY OF DEATH Carroll | | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION Hampstead | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll | | 10e. STREET AND NUMBER 3428 Shiloh Road | | 10f. ZIP CODE 21074 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 3 X Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 years | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Switchboard Operator | | 16b. KIND OF BUSINESS/INDUSTRY Baker-Watts | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Emerson C. Richardson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Susie V. Collins | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) H. Catherine Shaffer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3428 Shiloh Road Hampstead, MD 21074 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park Jan 6 | | DATE Jan 6 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas Joseph Bozek | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, MD 21212 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Coronary Artery Disease b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Myeloproliferative Disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 X Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Robert J. Moss, M.D. | | | | 29c. LICENSE NUMBER 032282 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Moss M.D. 114 Business Center Drive, Reisterstown, MD 21136 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00035

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Alverta Sarah Gore | | | | 2. DATE OF DEATH JAN 1 1994 | | 3. TIME OF DEATH 4:05A | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 215 22 6416 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Howard House | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Union Bridge | | | | 9c. COUNTY OF DEATH Carroll County | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll County | | 10c. CITY, TOWN OR LOCATION Finksburg | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 2221 Bollinger Mill Road | | | | 10f. ZIP CODE 21048 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY Domestic | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jacob Powder | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche Barnes | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Robert P. Gore | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Fox Meadow Garth Westminster, MD 21157 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Providence Cemetery Jan. 5, 1994 Finksburg, MD | | 20c. LOCATION — City or Town, State | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian J. Haight | | | | 22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ATRIAL FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF): CORONARY HEART DISEASE Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death YEARS 11 | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RECURRENT TIAs | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) DOM. HOME | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER J. H. Caricofe MD | | 29c. LICENSE NUMBER D906 | | 29d. DATE SIGNED (Month, Day, Year) JAN 1 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) J. H. Caricofe MD 104 N. Main Union Bridge MD 21791 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE Julius Davidson | | | | | | | | | |

20 00000

1300

1300

1300

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00036

REG. NO.

| | | | | | | | | | | | |
|---|---------------------|---|--|---|--|--|--|------------------------------|---------------------|---------------------------------|---------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) Goodwin, Mary ELEANOR GOODWIN | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 02 94 | | 3. TIME OF DEATH 12:05 A. M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-01-8160 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 07-02-15 | | | | | |
| 8a. FACILITY NAME (If not institution, give street and number) 1204 WESTERLEE PLACE | | | | 8b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE | | 8c. COUNTY OF DEATH MARYLAND | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION CATONSVILLE | | | | | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1204 WESTERLEE PLACE | | | | | | | |
| 10f. ZIP CODE 21228 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) SECRETARY | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY | | 16b. KIND OF BUSINESS/INDUSTRY LEGAL SECRETARY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) FREDERICK E. JOHNSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ETTA FRANCIS | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) FREDERICK GOODWIN (SON) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3102 DORAL COURT ELLICOTT CITY MARYLAND 21042 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) NEW CATHEDRAL CEMETERY 1/6/94 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | 20d. DATE 1/6/94 | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="1"> <tr> <td>Myocardial Infarction</td> <td>> 12 mos.</td> </tr> <tr> <td>Congestive Heart Failure</td> <td>> 12 mos.</td> </tr> </table> | | | | | | | | Myocardial Infarction | > 12 mos. | Congestive Heart Failure | > 12 mos. |
| Myocardial Infarction | > 12 mos. | | | | | | | | | | |
| Congestive Heart Failure | > 12 mos. | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| | | 28d. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 032319 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Raymond Plack MO 3449 Wilkens Ave Baltimore, MD 21229 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed with the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, the medical examiner must be notified at once.

AMERICAN

RECORDS

1

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00037

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eugene Hansen | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 1, 1994 | | 3. TIME OF DEATH M M | |
| 4. SOCIAL SECURITY NUMBER 542-16-1752 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Mar 1, 1909 | |
| 8. FACILITY NAME (If not Institution, give street and number) Fairfield Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Crownsville | | 9c. COUNTY OF DEATH Anne Arundel | |
| 10a. STATE MD | | | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Crownsville | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER Fairfield Loop Road | | | | 10f. ZIP CODE 21032 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chef | | 16b. KIND OF BUSINESS/INDUSTRY Restaurants | |
| 17. FATHER'S NAME (First, Middle, Last) George Hansen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Christina Hansen | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gene Hansen | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2991 Southaven Dr. Annapolis, MD 21401 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Hardesty</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → emphysema | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stuart E. Selovich, MD</i> | | | | 29c. LICENSE NUMBER 019838 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stuart E. Selovich 900 Bestgate Rd. Annapolis, Md. 21401 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 4 1994 | | 32. REGISTRAR'S SIGNATURE <i>Julia Benson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(14)

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00038

| | | | | | | | |
|--|--|---|--|--|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Haynes | | | | 2. DATE OF DEATH MONTH 1 DAY 2 YEAR 94 | | 3. TIME OF DEATH 4 P.M. | |
| 4. SOCIAL SECURITY NUMBER 25-14-8390 | | 5. SEX 1 M 2 F | 8. AGE (In yrs. last birthday) 80 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 5-07-13 | |
| 9a. FACILITY NAME (If not Institution, give street and number) Heridian Commwell Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER 8710 Emmerge Road | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unknown | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Artie Shaw | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 861 Park Ave., Baltimore, MD 21201 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery 1/4/94 | | 20c. LOCATION — City or Town, State Lansdown, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Albert P. Wylie F/H 638 N. Gilmore Street, Balto. MD 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of esophagus DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia Demented | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | |
| 27. MANNER OF DEATH 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 4 Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Marian Kowalewski MD | | | | 29c. LICENSE NUMBER D21022 | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8604 Hayford Rd Balto MD 21234 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

100 100 100 100



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is completed, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00039 | | | |
|--|--|--|--|---|---|--|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Thelma GRACE ALBAN Hanson | | | | 2. DATE OF DEATH MONTH Jan DAY 1 YEAR 1994 | | 3. TIME OF DEATH 3:55 am | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-05-5388 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 78 YRS. | IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) JUNE 10, 1915 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland | | | 9c. COUNTY OF DEATH Baltimore | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2715 CHRISTOPHER AVENUE | | 10f. ZIP CODE 21214 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BOOK KEEPER | | 16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH C. ALBAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ADDIE M. HEFLEIN | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) DONALD F. HANSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2809 GARNET ROAD BALTIMORE, MD. 21234 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY | | DATE 1/4/94 | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> JOHN E. DOLAN | | | | 22. NAME AND ADDRESS OF FACILITY LEONARD J. RUCK INC. 5305 HARFORD ROAD BALTIMORE, MD. 21214 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → INTRACEREBRAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST atrial fibrillation with rapid ventricular response DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death 2 WEEKS 2 WEEKS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA CHRONIC OBSTRUCTIVE PULMONARY DISEASE CONGESTIVE HEART FAILURE | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Louis E. Nielsen, MD.</i> | | 29c. LICENSE NUMBER D38327 | | 29d. DATE SIGNED (Month, Day, Year) 1/1/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 120 SISTER PIERRE DR; SUITE 105; TOWSON, MD 21204 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Russell</i> | | | | | | | |

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00040

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Marguerite Theresa Jones | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 2 1994 | | 3. TIME OF DEATH 12P.M. | |
| 4. SOCIAL SECURITY NUMBER 220-05-0089 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 96 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 25, 1897 | |
| 9a. FACILITY NAME (If not institution, give street and number) Meridian-Long Green Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Maryland | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6515 Glenoak Avenue | | | | 10f. ZIP CODE 21214 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (14 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerical | | 16b. KIND OF BUSINESS/INDUSTRY Insurance | | | |
| 17. FATHER'S NAME (First, Middle, Last) Theodore C. Schleeter | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Louisa Gabel | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert T. Jones | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6515 Glenoak Avenue Baltimore, Maryland 21214 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Zion Lutheran Church Cem 1-6-94 | | 20c. LOCATION — City or Town, State Baltimore, MD. | | 20d. DATE 1-6-94 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASCVD | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. Hypertension | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DJD SPINE MALNUTRITION | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29a. SIGNATURE AND TITLE OF CERTIFIER <i>Carl Sperling MD</i> Physician | | | | 29c. LICENSE NUMBER D28987 | | 29d. DATE SIGNED (Month, Day, Year) 1-3-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Carl Sperling 5601 Loch Raven Blvd. Baltimore, Maryland 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00041

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLARD CHARLES JENKINS | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 3, 1994 | | 3. TIME OF DEATH 2:40 A M | |
| 4. SOCIAL SECURITY NUMBER 236 12 4767 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JUNE 4, 1916 | |
| 9a. FACILITY NAME (If not institution, give street and number) V.A. MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH FORT HOWARD | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION Brooklyn Park, Md. | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 5517 PATRICK HENRY DRIVE | | | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WORLD WAR II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1st Grade | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Coal Miner | | 16. KIND OF BUSINESS/INDUSTRY America United Miners of | | | |
| 17. FATHER'S NAME (First, Middle, Last) Everett Jack Jenkins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Emily Whitehair | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Edith V. Lewis | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5517 Patrick Henry Dr. Balto. Md. 21225 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. Vet. Cemt, Crownsville 1/3 | | 20c. LOCATION — City or Town, State Crownsville, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David A. Taylor</i> | | | | 22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA OF LUNG DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Lopez MD</i> | | | | 29c. LICENSE NUMBER D 15232 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAUL LOPEZ, M.D., 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | 32. REGISTRAR'S SIGNATURE <i>John B. Anderson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10000 48

SECRET

EXHIBITION 41813

10000 48

SECRET

EXHIBITION 41813

17

UNCLASSIFIED

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00042 | | | | | |
|---|--|--|---|---|---|---|--|---|--|----------------------------------|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Sister Mary Elizabeth Lell | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 2 1994 | | 3. TIME OF DEATH 7:45A M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-62-6268 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 79 YRS. | 7. DATE OF BIRTH (Month, Day, Year) June 15, 1914 | 8. BIRTHPLACE (State or Foreign Country) Germany | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Villa Assumpta, 6401 N. Charles St. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 6401 N. Charles St., | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Education | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Josef Lell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Katharine Bruetting | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) S. Bernice Feilinger, SSND | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 N. Charles St., Baltimore, Md. 21212 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Villa Maria Cemetery 1/4 | | DATE 1/4 | | 20c. LOCATION — City or Town, State Glen Arm, Md. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis Stephen Xenakis MD0640 | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular disease DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerotic Cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 month many years | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER L. Boas MD | | 29c. LICENSE NUMBER D15871 MD | | 29d. DATE SIGNED (Month, Day, Year) 1/13/93 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LAWRENCE BOAS MD 54 Scott Adams Rd Cockeysville Md 21030 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randell | | | | | | | | | |

94 00043

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>William Lombardi</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>Jan 02 94</i> | | | | 3. TIME OF DEATH <i>12:53 A M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>705109556</i> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>84</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>JULY 21, 1909</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Italy</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>GOOD SAMARTIAN HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i> | | | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY <i>BALTIMORE</i> | | 10c. CITY, TOWN OR LOCATION <i>LUTHERVILLE</i> | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>2120 DULANEY VALLEY ROAD</i> | | | | 10f. ZIP CODE <i>21093</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>GENERAL YARD MASTER</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>RAILROAD</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>ANTONIO LOMBARDI</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>CLEONICIA LOMBARDI</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>GLORIA SEMENTA</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2120 DULANEY VALLEY ROAD LUTHERVILLE, MD. 21093</i> | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>DULANEY VALLEY CEM.</i> | | 20c. DATE <i>1/5/94</i> | | 20d. LOCATION — City or Town, State <i>TOWSON, MD.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>LEONARD J. ROCK INC. 5305 HARFORD ROAD BALTIMORE, MD. 21214</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Dissecting Thoracic Aortic Aneurysm</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death <i>11:00 → 12:53</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Hazem Andary M.D.</i> | | | | | | 29c. LICENSE NUMBER <i>019</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>Jan 2, 94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>HAZEM ANDARY - GSH</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>Jan 04 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John E. Dolan</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00044

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN MATTHEWS | | | | 2. DATE OF DEATH MONTH 01 DAY 01 YEAR 1994 | | 3. TIME OF DEATH 2:49 P M | |
| 4. SOCIAL SECURITY NUMBER 220-36-2821 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 52 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/13/41 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MD | | 10b. COUNTY BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1303 Edmondson Avenue | |
| 10f. ZIP CODE 21217 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) John Matthews | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Gorman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Avery D. Waller | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1811 W. Lafayette Avenue, Balto. MD 21217 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 1/4/94 | | 20c. LOCATION — City or Town, State Catonsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Albert P. Wylie F/H 638 N. Gilmore St. Balto., MD 21217 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND OF CHEST DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input checked="" type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 01/01/1994 | | 28b. TIME OF INJURY 2:15 P M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT ON STREET | | | |
| 28e. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify) STREET | | | | 28f. LOCATION (Street and Number or Rural Route Number) 1303 E. EDMONDSON AVENUE BALTIMORE, MARYLAND 21217 | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. Wallace McKeel M.D. | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/02/1993 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARRISON A. KORON 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00045 | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | | | |
| WILLIAM LEWIS MORRIS JR. | | | | MONTH 1 DAY 2 YEAR 94 | | | | 1:00 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | |
| 407-34-7762 | | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 74 YRS. | | MONTHS DAYS HOURS MIN. | | | | 08-14-19 | | KENTUCKY | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | | | |
| 229 N. BEAUMONT AVENUE | | | | CATONSVILLE | | | | BALTIMORE | | | | | |
| 10a. STATE | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | |
| MARYLAND | | | | BALTIMORE | | | | CATONSVILLE | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | |
| 229 N. BEAUMONT AVENUE | | | | 21228 | | | | U.S.A. | | | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | | | | | |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | Specify: WHITE | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | CLERK | | SOCIAL SECURITY | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | |
| WILLIAM LEWIS MORRIS | | | | AURELIA ROSMOND TAYLOR | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | |
| LORRAINE D. MORRIS (WIFE) | | | | 229 N. BEAUMONT AVENUE CATONSVILLE MARYLAND 21228 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | OATE | | 20c. LOCATION — City or Town, State | | | | | | | |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | METRO CREMATORY 01-04-94 | | | | CATONSVILLE, MARYLAND | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| | | | | LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | | | | |
| a. METASTATIC NON-SMALL CELL LUNG CANCER | | | | | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| ① INTESTINAL OBSTRUCTION | | | | | | | | | | | | | |
| ② CEREBROVASCULAR DISEASE | | | | | | | | | | | | | |
| ③ HYPERTENSION | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | 24a. WAS AN AUTOPSY PERFORMED? | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | | | | | | | | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) | | | | | |
| | | | | D40059 | | | | 1/3/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | | |
| THOMAS DONNER MD UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE MD 21201 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | |
| 1/3 JAN 4 1994 | | | | | | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed within 72 hours after death, it should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00046 | | | | | |
|--|--|---|--|---|--|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT MCCOY | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 2, 1994 | | | | 3. TIME OF DEATH 1:20 a.m. M | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-28-0857 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 05-18-28 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 514 CHAPELGATE LANE | | | | 10f. ZIP CODE 21229 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREA | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) REALTOR | | 15b. KIND OF BUSINESS/INDUSTRY REAL ESTATE | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) ROBERT L. MCCOY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) KATHRYN A. KLEINHANS | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOHN L. MCCOY (SON) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11965 SIMPSON ROAD CLARKSVILLE MARYLAND 21029 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. JOHN'S CEMETERY 01/05/94 | | OATE | | 20c. LOCATION — City or Town, State ELLICOTT CITY, MARYLAND | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hepatic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): b. Upper GI bleed DUE TO (OR AS A CONSEQUENCE OF): c. Esophageal varices DUE TO (OR AS A CONSEQUENCE OF): d. Hepatitis B cirrhosis | | | | | | | | Approximate Interval Between Onset and Death 2 days 3 days 6 mon 9 yr | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Oral / Esophageal candidiasis Retroviral infection | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Audrey Ho, MD | | | | 29c. LICENSE NUMBER 41017 | | 29d. DATE SIGNED (Month, Day, Year) 1/2/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Audrey Ho, MD 600 N. Wolfe St Baltimore MD 21205 | | | | 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00047

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH A. NORTON | | | 2. DATE OF DEATH MONTH 01 DAY 02 YEAR 94 | | 3. TIME OF DEATH 5:17 P M | | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-36-0409 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 55 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04-24-38 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) SHOCK TRAUMA CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | 9c. COUNTY OF DEATH | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY CARROLL | | 10c. CITY, TOWN OR LOCATION ELDERSBURG | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 6514 CARROLL HIGHLANDS ROAD | | | | 10f. ZIP CODE 21784 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAY OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES | | | 16b. KIND OF BUSINESS/INDUSTRY CARPET | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH NORTON SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN ZIEGLER | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARIE NORTON (WIFE) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6514 CARROLL HIGHLANDS ROAD ELDERSBURG MARYLAND 21784 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) NEW CATHEDRAL CEMETERY 01/06-94 | | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Head Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. DATE OF INJURY (Month, Day, Year) 12/27/93 | | 28b. TIME OF INJURY A M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT FELL AT HOME | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6514 CARROLL HIGHLANDS | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i> | | | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/03/1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The undersigned certifies that the death certificate was executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00048

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) THEODORE Eugene PINKNEY | | | | 2. DATE OF DEATH MONTH 01 DAY 02 YEAR 1994 | | 3. TIME OF DEATH 0430 AM | | | |
| 4. SOCIAL SECURITY NUMBER 218-36-8500 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 51 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03-15-42 | | 8. BIRTHPLACE (State or Foreign Country) Balto. Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7718 Liberty Rd. | | | | 10f. ZIP CODE 21244 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WORK OR DATES 3-31-60 3-30-66 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mail Carrier | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Pinkney | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Cromwell | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dereese M. Pinkney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7718 Liberty Rd. Baltimore, Maryland 21244 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem. 1-8 | | DATE Owings Mills, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY William C. Brown Community F.H. 1206 W. North Ave. Balto. Md. 21217 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Respiratory failure</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 2 days | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>metastatic cancer to lung</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 3 month | |
| c. <u>Squamous cell carcinoma Tongue</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 10 month | |
| d. | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D28133 | | 29d. DATE SIGNED (Month, Day, Year) 1-2-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suite 200 6569 N Charles St Baltimore Md 21208 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11-2-10 F-101-12

11-2-10 F-101-12

11-2-10 F-101-12

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00049

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Dorothy Ward Pritchett | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 2, 1994 | | 3. TIME OF DEATH M M | |
| 4. SOCIAL SECURITY NUMBER 012-18-9179 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 20, 1911 | |
| 8. BIRTHPLACE (State or Foreign Country) New York | | | | 9a. FACILITY NAME (If not institution, give street and number) Ginger Cove Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis | |
| 9c. COUNTY OF DEATH Anne Arundel | | | | 10a. STATE MD | | 10b. COUNTY Anne Arundel | |
| 10c. CITY, TOWN OR LOCATION Annapolis | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1101 River Crescent Drive | |
| 10f. ZIP CODE 21401 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | | | 16b. KIND OF BUSINESS/INDUSTRY Homemaker | | | |
| 17. FATHER'S NAME (First, Middle, Last) Richard Ward | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Mary Cruibley | | | |
| 19a. INFORMANT'S NAME (Type/Print) Donald G. Fraasa | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2705 Thyme Dr. Edgewater, MD 21037 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas J. Harker | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Recent Acute myocardial infarction Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Generalized arterio-scler. Cardio-vascular disease years Arterial Hypertension decades | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multi-infarct dementia Renal failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Peter F. Verkouw | | | | 29c. LICENSE NUMBER D11653 | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER F. VERKOUW 1833 Forest Dr. Annapolis MD 21401 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE John S. Russell | | | |

12 KIDNEY AVE. WILMINGTON, DEL.

12 KIDNEY AVE. WILMINGTON, DEL.

Post-acute myocardial infarction
Generalized arterio-sclerotic changes
Arterial hypertension
± 2 mls
decreased

Myth - infant demerol
level 100

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00050

| | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---------------------------------|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HAROLD | | | | ROBINSON | | | | 2. DATE OF DEATH MONTH Jan DAY 1 YEAR 1994 | | 3. TIME OF DEATH 11:33 pm | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 181-09-8100 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 90 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) July 3, 1903 | | | | | | | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland | | | | 9c. COUNTY OF DEATH Baltimore | | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | | | 10c. CITY, TOWN OR LOCATION Towson | | | | | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 748 Camberley Circle | | | | 10f. ZIP CODE 21204 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Regional Claims Manager | | | | 15b. KIND OF BUSINESS/INDUSTRY Hartford Insurance Co. | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Robinson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN UNKNOWN | | | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs Nancy N. Robinson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As #10 | | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 1-3-94 | | | | DATE | | | | 20c. LOCATION — City or Town, State Towson, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 | | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PROBABLE STROKE DUE TO (OR AS A CONSEQUENCE OF): b. VENTRICULAR FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate Interval Between Onset and Death 2 HOURS 2 MINS. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HX. C.V.A. HX. CARDIAC ARRHYTHMIAS | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | 29c. LICENSE NUMBER BP 3016943 | | 29d. DATE SIGNED (Month, Day, Year) 1/2/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAYNE DERRICK M.D. ST. JOSEPH HOSPITAL TOWSON, MD. 21204 | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | | | | | | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

Page 1 of 1

Subject: [Illegible]

Date: [Illegible]

Time: [Illegible]

Location: [Illegible]

Weather: [Illegible]

Remarks: [Illegible]

Signature: [Illegible]

Print Name: [Illegible]

Rank: [Illegible]

Unit: [Illegible]

Remarks: [Illegible]

Signature: [Illegible]

Print Name: [Illegible]

Rank: [Illegible]

Unit: [Illegible]

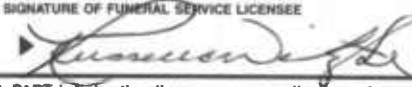
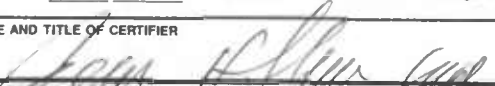
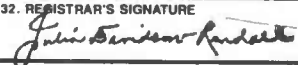
Remarks: [Illegible]

94 00051

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM WARD RIGGS | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN 2 1994 | | 3. TIME OF DEATH 6:45 A M | | | |
| 4. SOCIAL SECURITY NUMBER 215 07 5290 | | 5. SEX 1 M 2 F | | 8. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 24 1906 | | | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION CATONSVILLE | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| 10e. STREET AND NUMBER 2 HOWARD AVENUE | | | | 10f. ZIP CODE 21228 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) GREEN HOUSE WORKER | | 15b. KIND OF BUSINESS/INDUSTRY FLORIST | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) URIAH RIGGS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GERTHEW M. CRIDER | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) DANIEL RIGGS (BROTHER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 HOWARD AVENUE CATONSVILLE MD. 21228 | | | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEMETERY 1/5/94 | | 20c. LOCATION — City or Town, State WOODLAWN MD. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY LEROY & RUSSELL WITZKE FUNERAL HOME 1630 EDMONDSON AVE. BALTO. MD. 21228 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. RIGHT PLEURAL EFFUSION DUE TO (OR AS A CONSEQUENCE OF): d. DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | | | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D12967 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print) DR JOHN SHAW 5800 EDMONDSON AVE BALTO, MD 21228 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00052 | | | |
|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) LAMAR (NMN) ROYER | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 2, 1994 | | 3. TIME OF DEATH 9:00 AM M | | | |
| 4. SOCIAL SECURITY NUMBER 282-16-5597 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 7, 1923 | | | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 303 CHALMERS AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | | 9c. COUNTY OF DEATH ANNE ARUNDEL | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION GLEN BURNIE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 303 CHALMERS AVENUE | | | | 10f. ZIP CODE 21061 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) EXTRUSION PRESS OPERATOR | | 15b. KIND OF BUSINESS/INDUSTRY KAISER ALUMINUM | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JACOB N. ROYER | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) HULDA KOONS | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) CHARLOTTE A. ROYER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 CHALMERS AVENUE, GLEN BURNIE, MARYLAND 21061 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERANS CEMETERY | | DATE 1994 | | 20c. LOCATION — City or Town, State CROWNSVILLE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jefferson Nelson Zumburn</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Cholesterol</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Arteriosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Diabetes</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Obesity</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Smoking</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Alcoholism</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Stress</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Family History</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Genetics</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Age</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Other</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 26d. DESCRIBE HOW INJURY OCCURED | | | | | |
| 26e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John C. Healy, M.D.</i> | | | | 29c. LICENSE NUMBER 005596 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John C. Healy - 1311 FRANKLIN AVE - BALTO MD 21215 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John C. Healy</i> | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00053 | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) John Stevenson | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 2, 1994 | | 3. TIME OF DEATH M M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 718-14-9283 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Apr. 16, 1908 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Severna Park | | 9c. COUNTY OF DEATH Anne Arundel | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Millersville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 1729 Baldwin Drive | | | | 10f. ZIP CODE 21108 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor | | 16b. KIND OF BUSINESS/INDUSTRY Carpentry Dept. of Navy | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Stevenson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Diver | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) John Leslie Stevenson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1729 Baldwin Drive, Millersville, MD | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FT. Lincoln Cemetery | | DATE Brentwood, MD | | 20c. LOCATION — City or Town, State Brentwood, MD | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert J. Allen</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridegley Ave. Annapolis, MD | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): Parkinson's Disease c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death 3 days | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>James Stevenson MD</i> | | 29c. LICENSE NUMBER D41339 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAMIE HARMON BRADNECK FAMILY PLATILE ARNOLD MD | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | 32. REGISTRAR'S SIGNATURE <i>John Stevenson</i> | | | | | | | | | | | |

1000

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00054

1. FOR
STATE
REGISTRAR

REG. NO.

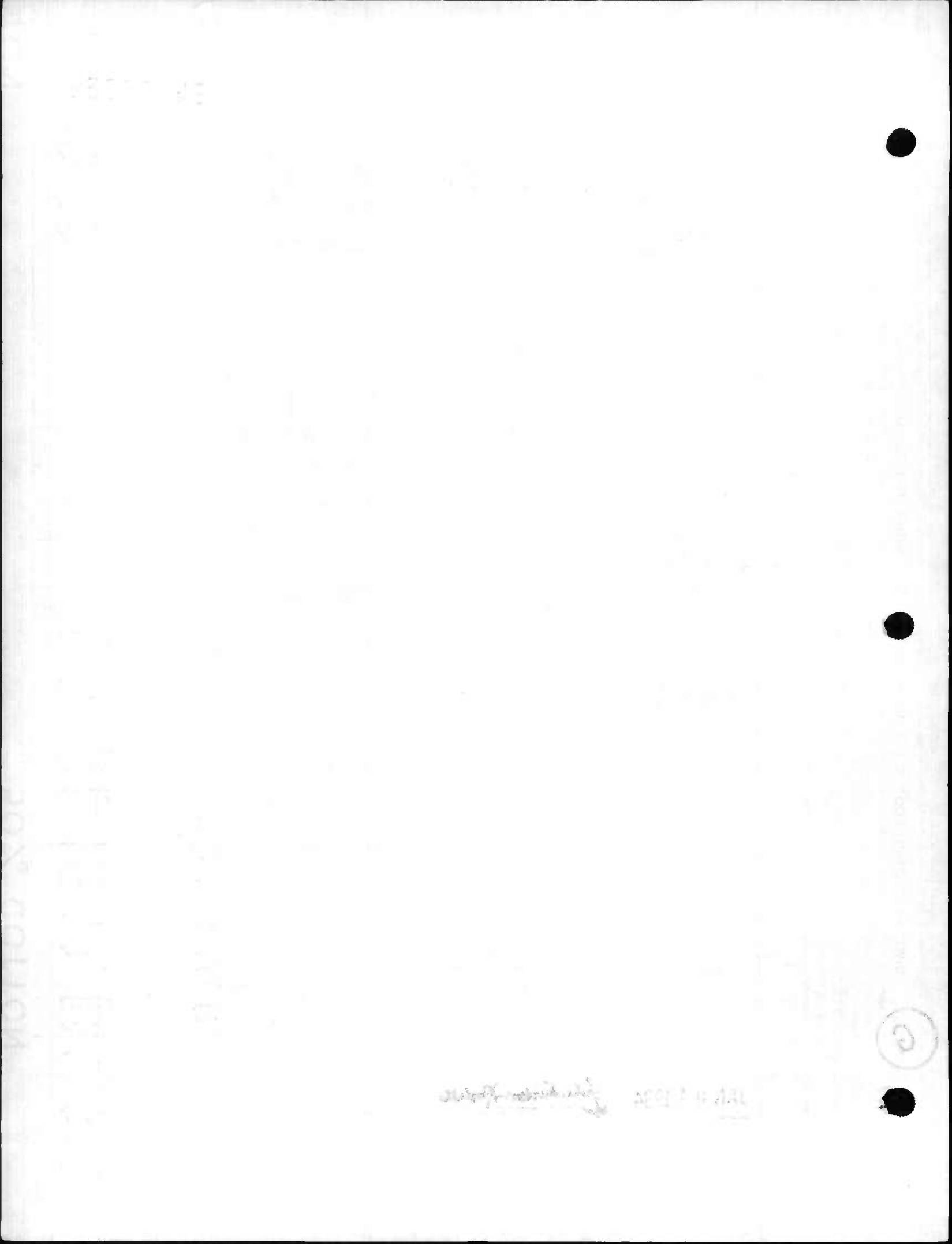
| | | | | | | | |
|---|--|--------------------------|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Bernadine Youtt Sheehan</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>2</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>9:25 P M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>069-03-7943</i> | | 5. SEX <i>1 M 2 F</i> | | 6. AGE (In yrs. last birthday) <i>88</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>12-17-05</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>New York</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>Manor Care Ruxton</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Towson</i> | |
| 9c. COUNTY OF DEATH <i>Baltimore</i> | | | | 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Baltimore</i> | |
| 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS? <i>1 YES 2 NO</i> | | 10e. STREET AND NUMBER <i>7138 Heathfield Road</i> | |
| 10f. ZIP CODE <i>21212</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 11. MARITAL STATUS <i>1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED</i> | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1 YES 2 NO</i> | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 YES 2 NO</i> | | 14. RACE — American Indian, Black, White, etc. <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>12</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Own</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Louis Youtt</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Mitchell</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>J.M. Sheehan</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>7138 Heathfield Road Baltimore, Maryland 21212</i> | | | |
| 20a. METHOD OF DISPOSITION <i>1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify)</i> | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St Joseph Cemetery</i> | | 20c. LOCATION — City or Town, State <i>Auburn, New York</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis Stephen Xenakis</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CORONARY THROMBOSIS</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death <i>1 day</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Lung Tumor - possible CARCINOMA.</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <i>1 YES 2 NO</i> |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1 YES 2 NO</i> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1 YES 2 NO</i> | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> OTHER: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i> | | | |
| 27. MANNER OF DEATH <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</i> | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | |
| 28c. INJURY AT WORK? <i>1 YES 2 NO</i> | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <i>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> <i>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>A.H. Gilahdi</i> | | | | 29c. LICENSE NUMBER <i>D-12849</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1-3-94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>A.H. Gilahdi 7001 North Charles Street Towson, Maryland 21204</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 04 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Burdon-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00055

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Alex DONALD STEWART | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 1, 1994 | | 3. TIME OF DEATH S A M | |
| 4. SOCIAL SECURITY NUMBER 480-40-3886 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 56 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 25, 1937 | |
| 8. BIRTHPLACE (State or Foreign Country) Iowa | | | | 9a. FACILITY NAME (If not institution, give street and number) 202 Duke of Kent | | 9b. CITY, TOWN OR LOCATION OF DEATH Cockeysville | |
| 9c. COUNTY OF DEATH Baltimore County | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Cockeysville | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 202 Duke of Kent | |
| 10f. ZIP CODE 21030 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 55-58 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) 12 years | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Tester | | 16b. KIND OF BUSINESS/INDUSTRY Industrial | |
| 17. FATHER'S NAME (First, Middle, Last) Alex Stewart | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Thelma Thoms | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ian Stewart | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7846 Americana Circle Glen Burnie, Maryland 21060 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 1-3 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George J. Ferrarse</i> George J. Ferrarse | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardio Respiratory failure</i> Due to (or as a consequence of): b. <i>Cor Pulmonale</i> Due to (or as a consequence of): c. <i>COPD</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Matus</i> M.D. A.H. Physician | | | | 29c. LICENSE NUMBER D-14618 | | 29d. DATE SIGNED (Month, Day, Year) 1/1/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bienvendio Matos, M.D. 21 Cranbrook Road, Cockeysville, MD 21030 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020. The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 00022

ST. ALBION
PROVINCE
XPOHIC

THE
FEBRUARY

1881-1882

2

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00056

| | | | | | | | |
|---|--|--|---|--|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Andrew Schmidt | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 - 01 - 94 | | 3. TIME OF DEATH 0200 M | |
| 4. SOCIAL SECURITY NUMBER 212-42-5768 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 49 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 3/11/44 | |
| 8. BIRTHPLACE (State or Foreign Country) Balt. MD | | | | 9. COUNTY OF DEATH | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Glen Burnie | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 304 Georgia Ave. | | | | 10f. ZIP CODE 21061 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 6+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Business Owner | | 16b. KIND OF BUSINESS/INDUSTRY Rental Equipment | | | |
| 17. FATHER'S NAME (First, Middle, Last) JACOB SCHMIDT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) RUTH ANN NOEL | | | |
| 19a. INFORMANT'S NAME (Type/Print) Yolanda Michael | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Georgia Ave. Glen Burnie, Md. 21061 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Cem. 1/4/94 | | 20c. LOCATION - City or Town, State Glen Burnie, MD | | 20d. DATE 1/4/94 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hilary L. Stallings Jr. | | | | 22. NAME AND ADDRESS OF FACILITY STALLINGS FUNERAL HOME P.A. 3111 Mountain Rd. Pasadena, MD. 21122 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. AORTOILIAC PERIPHERAL VASCULAR DISEASE 75 yrs Due to (or as a consequence of): b. COPD Due to (or as a consequence of): c. CHRONIC PANCREATITIS Due to (or as a consequence of): d. HTN Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHF, & CO, PULMONARY HTN | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER R. Wagner MD | | | | 29c. LICENSE NUMBER AT2438946 | | 29d. DATE SIGNED (Month, Day, Year) 1-1-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4322 FLINT HILL DR #304, OWINGS MILLS MD, 21117 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | 32. REGISTRAR'S SIGNATURE John Benson Russell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00057

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARIE M STRUBE | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 02 94 | | 3. TIME OF DEATH 08:00 AM | | | | | |
| 4. SOCIAL SECURITY NUMBER 214 22 8182 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 7, 1910 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION | | | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | | | 9c. COUNTY OF DEATH A.A. COUNTY | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Glen Burnie | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 7885 Gordon Ct. | | | | 10f. ZIP CODE 21061 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | 15b. KIND OF BUSINESS/INDUSTRY Domestic | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Herrman Dickerson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Tuiea Teanie Slivka | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) John J. Strube, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1528 Puffin Ct., Pasadena, MD 21122 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 1/5/94 | | DATE 1/5/94 | | 20c. LOCATION — City or Town, State Elkridge, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen D. Lohmeyer</i> | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Pasadena 3204 Mountain Rd. Pasadena, MD 21122 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Cerebrovascular Accident Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Aspiration Pneumonia c. Cardiac Arrhythmia d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - Hypertension | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Salvacion A. Dupaya</i> | | | | 29c. LICENSE NUMBER 038912 | | 29d. DATE SIGNED (Month, Day, Year) 01/02/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SALVACION A. DUPAYA, M.D./1720 CRAIN HIGHWAY, S. #204/GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | 32. REGISTRAR'S SIGNATURE <i>John D. Anderson</i> | | | | | | | | | |

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00058

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Handy Womble | | | | 2. DATE OF DEATH MONTH 01 DAY 02 YEAR 94 | | 3. TIME OF DEATH 6:20a M | |
| 4. SOCIAL SECURITY NUMBER 244-01-8893 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-11-11 | |
| 9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1315 Myrtle Ave | | | |
| 10f. ZIP CODE 21217 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Welder | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Don Womble | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Betty Mimms | | | |
| 19a. INFORMANT'S NAME (Type/Print) Betty W. Whitfield | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1315 Myrtle Ave. Baltimore, Maryland 21217 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.) King Park | | DATE 1-8 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY William C. Brown Community F.H. 1206 W. North Ave. Balto. Md. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Cerebrovascular Accident Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Pneumonia c. Congestive Heart Failure | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Kerren Eldermid House Officer | | | | 29c. LICENSE NUMBER D38993 | | 29d. DATE SIGNED (Month, Day, Year) 01/02/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Kerren Eldermid 22, South Grene St Baltimore 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: The death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00059

| | | | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VERA WRIGHT | | | | 2. DATE OF DEATH MONTH DAY YEAR January 1, 1994 | | 3. TIME OF DEATH 1:45 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-16-9249 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03-30-07 | | 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | 9c. COUNTY OF DEATH NONE | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE MARYLAND | | 10b. COUNTY NONE | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 918 N. CAROLINE ST. | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: AFRICAN AMERICAN | | | 14. RACE — American Indian, Black, White, etc. Specify: AFRICAN AMERICAN | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4 or 5+) none | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRESSER | | | 16b. KIND OF BUSINESS/INDUSTRY LAUNDRY | | | | |
| 17. FATHER'S NAME (First, Middle, Last) EDDIE LEE | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH HURT | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) CELESTINE JOHNSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 N. CAROLINE ST. BALTIMORE, MD. 21205 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 1/6/94 | | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Aspiration</u> (ASPIRATION) DUE TO (OR AS A CONSEQUENCE OF): b. <u>Encephalopathy</u> (ENCEPHALOPATHY) DUE TO (OR AS A CONSEQUENCE OF): c. <u>Seizures</u> (SEIZURES) DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 15 min. 1 month 1 month | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Aspiration Pneumonia</u> (ASPIRATION PNEUMONIA) | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO X | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Susan Ziemann, MD INTERN</i> | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/1/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUSAN ZIEMANN TOWER 110 JOHNS HOPKINS HOSP. BALTIMORE, MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1/1/JAN 04 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | | | |

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DATE: 10/10/1911

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94 00060

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HERBERT T. ALLISON | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 11:45 A | |
| 4. SOCIAL SECURITY NUMBER 220-10-4409 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 73 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 10 01 20 | |
| 9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH MARYLAND | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION PASADENA | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1427 AMPHIBIAN DRIVE | | | | 10f. ZIP CODE 21122 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW 11 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 04 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) AUDITOR | | 16b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT | |
| 17. FATHER'S NAME (First, Middle, Last) JACOB H. ALLISON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GLADY'S R. MYERS | | | |
| 19a. INFORMANT'S NAME (Type/Print) SARAH M. ALLISON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1427 AMPHIBIAN DRIVE-PASADENA, MD. 21122 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN CEMETERY | | DATE 1/7 | | 20c. LOCATION — City or Town, State GLEN BURNIE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry L. Kaufman</i> | | | | 22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ischemic Heart Disease a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Pitayadot Jum RUSSIRIAN</i> | | | | 29c. LICENSE NUMBER AS2441614-50 | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Jude Anderson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>NICHOLAS WILLIAM AUMILLER, Sr.</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>JAN 4 1994</i> | | | | 3. TIME OF DEATH <i>11:44 AM</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>218-01-9279</i> | | | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>82</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>11/1/1911</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>The Good Samaritan Hospital</i> | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | | 9c. COUNTY OF DEATH | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>Baltimore</i> | | | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>1650 Wadsworth Way</i> | | | | | | 10f. ZIP CODE <i>21239</i> | | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+) <i>2</i> | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Dispatch Captain</i> | | | | 15b. KIND OF BUSINESS/INDUSTRY <i>Baltimore City Fire Department</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>John Francis Aumiller</i> | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Margaret F. Mauer</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Patricia A. Jerrard</i> | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3204 Loch Raven Boulevard Baltimore, 21286</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Dulaney Valley Memorial Gardens 1/7/94</i> | | | | 20c. LOCATION — City or Town, State <i>Timonium, Maryland</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark T. Zavoyna</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY <i>Leonard J. Ruck, Inc. 5305 Harford Road</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ventricular tachycardia</i> | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| <i>ischemic cardiomyopathy</i> | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| Approximate interval between Onset and Death <i>2 mins</i> <i>3 years</i> | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CHRONIC RENAL FAILURE</i> | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide S <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) <i>NA</i> | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Guel. M.D.</i> | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>JAN 4, 1994</i> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>RAFI SABA MD 5601 LOCH RAVEN BLVD, BALTO, MD 21239</i> | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 05 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julius Sanders-Randall</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00062 | | | |
|---|--|--|--|---|--|--|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | |
| MARY E. ANDERSON | | | | MONTH 1 DAY 1 YEAR 94 | | | | 4 10 A M | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 214 20 5982 | | 1 M 2 F | | 93 YRS. | | 07/16/1900 | | Czechoslovakia | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| Church Home Hospital | | | | Baltimore City | | | | ===== | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | | | |
| 10a. STATE | | 10b. COUNTY | | Baltimore | | | | 1 X YES 2 NO | | | |
| 10a. STREET AND NUMBER | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 4002 Pennington Avenue | | 21226 | | U.S.A. | | | | | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | | | |
| 1 X Never Married 2 X Married 3 X Widowed 4 X Divorced | | 1 X YES 2 X NO IF YES, GIVE WAR OR DATES | | 1 X YES 2 X NO Specify: | | Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| Elementary/Secondary (0-12) 6th Grade | | College (1-4 or 5+) | | Cook | | Restaurant | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| John Sitar | | | | Suzanna | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| Maryann Grimm | | | | 344 Constant Avenue Severn, Maryland 21144 | | | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | | | |
| 1 X Burial 2 X Cremation 3 X Removal from State 4 X Donation 6 X Other (Specify) | | Holy Cross Cemetery | | 1/4 | | Baltimore, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| Jerome Znamionick | | | | George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | | |
| a. Sepsis | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| b. Streptococcal pneumonia cellulitis | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? | | | |
| Diabetes Mellitus Heart Failure | | | | | | | | 1 X YES 2 X NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | | 1 X YES 2 X NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| 1 X YES 2 X NO | | | | HOSPITAL: 1 X Inpatient 2 X ER/Outpatient 3 X DOA OTHER: 4 X Nursing Home 5 X Residence 6 X Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 X Natural 2 X Accident 3 X Suicide 4 X Homicide 5 X Pending Investigation 6 X Could not be determined | | | | | | M | | 1 X YES 2 X NO | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | 29b. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| Richard Kuhnmo | | | | D43349 | | | | 1/1/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| Richard Kuhnmo Church Hospital, Baltimore MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |
| JAN 05 1994 | | | | John Sitar | | | | | | | |

22000 42

Source: *U.S. Census Bureau, Current Population Reports, 1990*

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00063

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MILDRED DELORES BRADFORD | | | | 2. DATE OF DEATH MONTH DAY YEAR January 3, 1994 | | 3. TIME OF DEATH 1:18 P M | |
| 4. SOCIAL SECURITY NUMBER 218- 30- 5853 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05- 12- 35 | |
| 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | | 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH n/a | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1765 MONTEPELIAR STREET | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 TH College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED | | 16b. KIND OF BUSINESS/INDUSTRY n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES CARTER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) IRENE REGAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) VANESSA COCHRAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1765 MONTEPELIAR STREET, BALTIMORE, MARYLAND 21218 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) ARBUTUS MEMORIAL GARDEN | | DATE | | 20c. LOCATION — City or Town, State ARBUTUS, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH. 1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. CORONARY ARTERY DISEASE WITH ANGINA | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS, RENAL INSUFFICIENCY | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 19718 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N. WOLFE ST 110 TOWER BALTIMORE MD 21287 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

320000 49



ITEM: 18 PER F.H. G-707 1/18/94 reb

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00064

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) George W. Burse, Jr | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 1 1994 | | 3. TIME OF DEATH 12:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER 212-22-4946 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-24-26 | |
| 9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO | | 9c. COUNTY OF DEATH MD | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY BALTO | | 10c. CITY, TOWN OR LOCATION BALTO | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2323 N. LONGWOOD ST. | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNKNOWN | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE W. BURSE SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LUCY ASKES LUCIE ASKES Akes | | | |
| 19a. INFORMANT'S NAME (Type/Print) FRANCES BURSE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2323 LONGWOOD ST. BALTO, MD 21216 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet | | DATE 1694 | | 20c. LOCATION — City or Town, State Owings Mills, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE John March | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. Anoxic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death 5 days | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER George E. Wicks III M.D. | | 29c. LICENSE NUMBER D41365 | | 29d. DATE SIGNED (Month, Day, Year) Jan 1, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George E. Wicks III M.D. 2600 Liberty Heights | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE John Burden | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00065

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DR. I. NORTON BROTMAN | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN. 1, 1994 | | 3. TIME OF DEATH 5:10 AM | |
| 4. SOCIAL SECURITY NUMBER 217-38-0602 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 13, 1915 MD. | |
| 9a. FACILITY NAME (If not institution, give street and number) 7 SLADE AVE., APT. #818 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7 SLADE AVE., APT. #818 | | | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES W.W.II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 6+) 5+ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DENTIST | | 16b. KIND OF BUSINESS/INDUSTRY DENTISTRY | |
| 17. FATHER'S NAME (First, Middle, Last) ROBERT BROTMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SADIE | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. ESTHER BROTMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 SLADE AVE., APT. #818, BALTO., MD. (21208) | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON (CHIZUK AMUNO CONG.) 1/3/94 DATE | | 20c. LOCATION — City or Town, State BALTO. CITY | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Cutler</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD. (21215) | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lymphoma</i> | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <i>Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Shroeder MD Physician</i> | | | | 29c. LICENSE NUMBER D10036 MD | | 29d. DATE SIGNED (Month, Day, Year) 1/1/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 6804 Park Heights Ave Baltimore, Md 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John D. Sanderford</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: Also, the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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B.K.S

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00066

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JERRY CHATMAN | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 01 94 | | 3. TIME OF DEATH 7:55 A M | |
| 4. SOCIAL SECURITY NUMBER 220- 64- 0398 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 33 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10- 17- 60 | |
| 9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL E.R. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH n/a | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1132 E. NORTH AVENUE | | | | 10f. ZIP CODE 21202 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER | | 16b. KIND OF BUSINESS/INDUSTRY LORD of BALTIMORE CLEANERS | |
| 17. FATHER'S NAME (First, Middle, Last) DAVID LEE DEW | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) VIRGINIA CHATMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) VIRGINIA CARTER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1132 E. NORTH AVENUE, BALTIMORE, MARYLAND 21202 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or crematorium) KING MEMORIAL PARK | | DATE | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ACQUIRED IMMUNE DEFICIENCY SYNDROME</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Inquiry |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) 01/01/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR OUTPATIENT PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 94 00067

1. DECEDENT'S NAME (First, Middle, Last)
Frances Corinne Collins

2. DATE OF DEATH
MONTH DAY YEAR
Jan. 3, 1994

3. TIME OF DEATH
1:15A

4. SOCIAL SECURITY NUMBER
227-28-5811

5. SEX
1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday)
68 YRS.

7. DATE OF BIRTH (Month, Day, Year)
May 10, 1925

8. BIRTHPLACE (State or Foreign Country)
Maryland

9a. FACILITY NAME (If not institution, give street and number)
3443 Dunhaven Rd.

9b. CITY, TOWN OR LOCATION OF DEATH
Dundalk

9c. COUNTY OF DEATH
Baltimore

10a. STATE
Md.

10b. COUNTY
Baltimore

10c. CITY, TOWN OR LOCATION
Dundalk

10d. INSIDE CITY LIMITS?
1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER
3443 Dunhaven Rd.

10f. ZIP CODE
21222

10g. CITIZEN OF WHAT COUNTRY?
U.S.A.

11. MARITAL STATUS
1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12th

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Char-Woman

16b. KIND OF BUSINESS/INDUSTRY
Beth-Steel

17. FATHER'S NAME (First, Middle, Last)
Ernest Baugher

18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ruby Newton

19a. INFORMANT'S NAME (Type/Print)
James W. Collins

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3443 Dunhaven Rd. Baltimore, Md. 21222

20a. METHOD OF DISPOSITION
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Gardens of Faith 1/6

20c. LOCATION — City or Town, State
Baltimore, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Colt Connelly

22. NAME AND ADDRESS OF FACILITY
Connolly Funeral Home of Dundalk
7110 Sollers Pt. Rd. Dundalk 21222

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. *Cardiopulmonary arrest*
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. *Metastatic squamous cell carcinoma*
DUE TO (OR AS A CONSEQUENCE OF): 3 mo

c. *Squamous cell carcinoma base of skull 7mo*
DUE TO (OR AS A CONSEQUENCE OF):

d. *Squamous cell carcinoma temporal bone 1 yr*

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?
1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH
1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 8 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY
M

28c. INJURY AT WORK?
1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURRED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER
Michael J. Halliday MD

29c. LICENSE NUMBER
D18136

29d. DATE SIGNED (Month, Day, Year)
1/4/94

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JHOC 6244 - The Johns Hopkins Medical Institutions

31. DATE FILED (Month, Day, Year)
JAN 05 1994

32. REGISTRAR'S SIGNATURE
John Davidson-Randall

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



WILLIAM D. HARRIS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00068 | |
|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Rev. John Francis Cronin | | | | 2. DATE OF DEATH MONTH 1 DAY 2 YEAR 94 | | 3. TIME OF DEATH 11-50 A | |
| 4. SOCIAL SECURITY NUMBER 579-58-5874 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10/4/1908 | |
| 8. BIRTHPLACE (State or Foreign Country) New York | | | | 9. COUNTY OF DEATH Baltimore | | | |
| 10. FACILITY NAME (If not institution, give street and number) St. Charles Villa | | | | 11. CITY, TOWN OR LOCATION OF DEATH Catonsville | | 12. COUNTY OF DEATH Baltimore | |
| 13. RESIDENCE OF DECEDENT | | | | 14. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 15. STATE Maryland | | 16. COUNTY Baltimore | | 17. CITY, TOWN OR LOCATION Catonsville | | 18. ZIP CODE 21228 | |
| 19. STREET AND NUMBER 603 Maiden Choice Lane | | 20. CITIZEN OF WHAT COUNTRY? United States | | 21. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | |
| 22. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 24. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ | | 26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Catholic Priest | | 27. KIND OF BUSINESS/INDUSTRY Church | | | |
| 28. FATHER'S NAME (First, Middle, Last) Bernard Joseph Cronin | | 29. MOTHER'S NAME (First, Middle, Maiden Surname) Nora Reardon | | 30. INFORMANT'S NAME (Type/Print) Rev. Jerry Brown, S.S. | | | |
| 31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5408 Roland Ave. Baltimore, MD 21210 | | 32. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sulpician Cem. 1/6/94 Baltimore, MD | | 34. LOCATION — City or Town, State Baltimore, MD | |
| 35. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul L. Hartsock, Jr. | | 36. NAME AND ADDRESS OF FACILITY Baltimore, MD 21214 | | 37. SIGNATURE OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Rd. | | | |
| 38. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST CANCER OF LEGS | | | | 39. APPROXIMATE Interval Between Onset and Death | | | |
| 40. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 41. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 42. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 43. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 44. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 45. 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 46. 28a. DATE OF INJURY (Month, Day, Year) | | 47. 28b. TIME OF INJURY M | | 48. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 49. 28d. DESCRIBE HOW INJURY OCCURRED | |
| 50. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 51. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 52. 29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 53. 29a. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | 54. 29b. LICENSE NUMBER 021649 | | 55. 29c. DATE SIGNED (Month, Day, Year) 1-4-94 | | | |
| 56. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SANBANDAN BASKARAN 3455 Wilkens Ave. Baltimore MD 21229 | | | | | | | |
| 57. DATE FILED (Month, Day, Year) JAN 05 1994 | | 58. REGISTRAR'S SIGNATURE [Signature] | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 94 00069 | |
|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Solomon Caplan | | 2. DATE OF DEATH MONTH DAY YEAR 01 03 94 | | 3. TIME OF DEATH 0448A M | |
| 4. SOCIAL SECURITY NUMBER 216-01-3491 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 06-25-07 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 2518 Farrington Rd | | 10f. ZIP CODE 21209 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) MANAGEMENT | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MANAGEMENT | | 16b. KIND OF BUSINESS/INDUSTRY CAPLAN BROS. GLASS CO. | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM CAPLAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE HEYMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS SONIA CAPLAN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2518 FARRINGTON RD BALTIMORE, MD 21209 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) (ANSHE EMINAH) ATTZ CHAIM 1-4-94 BALTIMORE, MD | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial infarction. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Suspected Cardiac arrhythmia. | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Seizure disorder History of Alzheimers for 15 yrs. a feeding tube in place | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Frederick W. Randolph, MD | | 29c. LICENSE NUMBER D 19085 | |
| 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00070 | |
|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) John L. Delaney, Jr. | | | | 2. DATE OF DEATH MONTH 1 DAY 2 YEAR 94 | | 3. TIME OF DEATH 0020 AM | |
| 4. SOCIAL SECURITY NUMBER 212-52-6775 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 46 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 30, 1947 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Howard County General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Columbia | | 9c. COUNTY OF DEATH Howard | |
| 10a. STATE Maryland | | | | 10b. COUNTY Howard | | 10c. CITY, TOWN OR LOCATION Columbia | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 10001 Windstream Drive Unit 108 | | | | 10f. ZIP CODE 21044 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (14 or 5+) 4 yrs. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Vice-President | | 16b. KIND OF BUSINESS/INDUSTRY Riggs National Bank | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Leo Delaney, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Fearer | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Nancy Delaney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10001 Windstream Drive Unit 108 Columbia, Md. 21044 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 1-6-94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lassahn Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY 7401 Belair Rd. Lassahn Funeral Home Balto., Md. 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis of undetermined etiology DUE TO (OR AS A CONSEQUENCE OF): c. Marfan's Syndrome s/p Aortic valve, arch and abdominal aorta DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 3 hours 2 days | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>Autopsy being arranged</i> 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Russell O. Schub - physician</i> | | | | 29c. LICENSE NUMBER H35058 | | 29d. DATE SIGNED (Month, Day, Year) 1/2/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RUSSELL O. SCHUB, 5999 HARPER'S FARM ROAD, SUITE E215, COLUMBIA, MD 21044 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1/2/JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i> | | | |

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00071

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARION Thomas Dill | | | | 2. DATE OF DEATH MONTH 1 DAY 3 YEAR 94 | | 3. TIME OF DEATH 0933 | |
| 4. SOCIAL SECURITY NUMBER 216 76 8583 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 34 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1/6/59 | |
| 9a. FACILITY NAME (If not institution, give street and number) 521 Old Oak Rd | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Severn | | 9c. COUNTY OF DEATH AA | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4210 Frederick Avenue | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | 16b. KIND OF BUSINESS/INDUSTRY Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last) Donald Ellsworth Dill | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Sylvia Willey | | | |
| 19a. INFORMANT'S NAME (Type/Print) Victoria Lubinski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Chelmsford Court Balto., Md. 21220 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 1-4-94 | | DATE Baltimore, Md. | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler | | | | 22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224 Eastern Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Shotgun Wound Chest. | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER William P. Jones Deputy | | | | 29c. LICENSE NUMBER D 06054 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) William P. Jones, PO Box 99 20711 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE John Benveniste | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00072

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|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Catherine Durant | | | | 2. DATE OF DEATH MONTH DAY YEAR January 2 94 | | 3. TIME OF DEATH 7:30 P M | |
| 4. SOCIAL SECURITY NUMBER 213- 90- 9919 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 31 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 07- 29- 62 | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH n/a | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 500 E. 27 TH STREET | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 TH College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER | | 16b. KIND OF BUSINESS/INDUSTRY n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last) ISAAC DURANT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA WOODS | | | |
| 19a. INFORMANT'S NAME (Type/Print) EMMA DURANT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 E. 27 TH STREET, BALTIMORE, MARYLAND 21218 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHELL MEMORIAL GARDEN | | DATE | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See V. Holland</i> | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH.- 1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>AIDS</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 year | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER Beep 319 | | 29d. DATE SIGNED (Month, Day, Year) Jan 2 94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Salim Hamadi, AMH, 201 E University Parkway Balt MD 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00073

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) TARVER A. DUNAWAY | | | | 2. DATE OF DEATH MONTH 1 DAY 3 YEAR 94 | | 3. TIME OF DEATH 2:24 p.m. | |
| 4. SOCIAL SECURITY NUMBER 225-10-1176 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-30-19 | |
| 9a. FACILITY NAME (If not institution, give street and number) 8561 Horseshoe Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Ellicott City | | 9c. COUNTY OF DEATH Howard | |
| 10a. STATE Md. | | 10b. COUNTY Howard | | 10c. CITY, TOWN OR LOCATION Ellicott City | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8561 Horseshoe Rd. | | | | 10f. ZIP CODE 21043 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chauffeur | | 16b. KIND OF BUSINESS/INDUSTRY Hall's Motor | | | |
| 17. FATHER'S NAME (First, Middle, Last) Norman Dunaway | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Delia Saunders | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy V. Dunaway | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8561 Horseshoe Rd. - Ellicott City, Md. 21043 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 1-6-94 Balto., Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE G. Truman Schwab | | | | 22. NAME AND ADDRESS OF FACILITY 5151 Baltimore National Pike Baltimore, Md. 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> CIGARET SMOKING CARDIOVASCULAR DISEASE </div> <div style="width: 35%;"> Approximate interval Between Onset and Death </div> </div> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26e. DESCRIBE HOW INJURY OCCURRED | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Joseph A. Lewis | | | | 29c. LICENSE NUMBER D27843 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH ALEX 4801 DORSEY HALL RD ELLICOTT CITY MD 21042 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | 32. REGISTRAR'S SIGNATURE John Sanders | | | | | |

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00074

REG. NO.

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|---|--|--|---|--|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William S. Ervin | | | | 2. DATE OF DEATH MONTH DAY YEAR January 4, 1994 | | 3. TIME OF DEATH 1:00 P. M. | |
| 4. SOCIAL SECURITY NUMBER 217-12-8750 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 69 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) July 15, 1924 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) 9901 Berliner Court, Apartment L | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH Baltimore County | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore County | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 9901 Berliner Court, Apartment L | |
| 10f. ZIP CODE 21220 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII and Korea | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician | |
| 16b. KIND OF BUSINESS/INDUSTRY Baltimore City Department of Education | | 17. FATHER'S NAME (First, Middle, Last) William E. Ervin | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Theresa Kershner | | 19a. INFORMANT'S NAME (Type/Print) Mary E. Venanzi | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5701 Plainfield Avenue, Baltimore, Maryland 21206 | | 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cemetery 1/5/94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Matthew M. Murphy</i> | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ACUTE MYOCARDIAL Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ASCVD</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Congestive heart failure</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>COPD</u> <u>Renal impairment</u> <u>Hypertension</u> | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c. LICENSE NUMBER D17728 | | 29d. DATE SIGNED (Month, Day, Year) January 4, 1994 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ba Yin Oung, M.D., 8022 Belair Road, Baltimore, Maryland 21236 | |
| 31. DATE JAN 05 1994 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | 33. SIGNATURE OF PHYSICIAN <i>[Signature]</i> | | 34. SIGNATURE OF FUNERAL HOME <i>[Signature]</i> | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24 00076

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00075

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HANSHEW JOANNE GLOVER | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 3:45 A M | | | |
| 4. SOCIAL SECURITY NUMBER 213-58-0396 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 42 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 10/31/51 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | | | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 10e. STREET AND NUMBER 8637 Willow Oak Road | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 1 yr | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Letter Carrier | | 16b. KIND OF BUSINESS/INDUSTRY U.S. Postal Service | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Owen W. James | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth B. Benedict | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) William Glover | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8637 Willow Oak Road Towson, MD 21234 | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 1/5/94 | | 20c. LOCATION — City or Town, State Catonsville, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Brain metastasis DUE TO (OR AS A CONSEQUENCE OF): c. Pulmonary failure DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Paul Celano MD | | | | 29c. LICENSE NUMBER D30929 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL CELANO GBMC Care Center Baltimore MD 21204 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | |

31 0005

NEW YORK

NEW YORK

NEW YORK

NEW YORK



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00076

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|---------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ELIZA Frances GERMAN | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN 1 1994 | | 3. TIME OF DEATH 3:30 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-05-6935 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov 16 1910 | | 8. BIRTHPLACE (State or Foreign Country) Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 3434 AUCHENTROLY TERRACE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | 9c. COUNTY OF DEATH | | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10e. STREET AND NUMBER 3434 Auchentroly Terrace | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Rodney Robinson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eliza Nelson | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Barbara Porter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Park Avenue Baltimore, MD | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore National 1/1 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vernon R. Bailey | | | | 22. NAME AND ADDRESS OF FACILITY NUTEN FURNITURE HOME 2501 EUGENES FARM RD. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>hypoxia</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. <u>Cancer</u> | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Michael T Collins | | | | 29c. LICENSE NUMBER D45237 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael T Collins 22 S. Greene St Balto MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE John Benson-Randall | | | | | | | |



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00077

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Garnis, Angela</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>01 03 94</i> | | 3. TIME OF DEATH <i>1930</i> M | | | |
| 4. SOCIAL SECURITY NUMBER <i>214-34-3999</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>95</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>08/16/1898</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Greece</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Union Memorial Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | | | 9c. COUNTY OF DEATH <i>CITY</i> | |
| 10a. STATE <i>Md.</i> | | | | 10b. COUNTY <i>City</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>7018 Holabird Avenue</i> | | | | 10f. ZIP CODE <i>21222</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never-Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>white</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Self-Employed</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Nicholas Yanacaris</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Rose</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Phillip W. & Katherine</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2416 Keyway Baltimore, Maryland 21222</i> | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oak Lawn</i> | | DATE <i>1/6</i> | | 20c. LOCATION — City or Town, State <i>Baltimore, Md.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Colt Connelly</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Connelly Funeral Home of Dundalk 7110 Sollers Pt. Rd. Baltimore, 21222</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>ischemic heart dis.</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>Renal insufficiency</i> <i>multiple</i> <i>MI</i> | | | | | | | | Approximate Interval Between Onset and Death <i>one mo</i> <i>20yrs</i> | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>ECU</i> <i>Senior Home</i> | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wm. F. Renner</i> <i>MD</i> | | 29c. LICENSE NUMBER <i>009760</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/4/94</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Wm. F. Renner</i> <i>3222 St. Paul</i> <i>Balt</i> | | | | 31. DATE FILED (Month, Day, Year) <i>JAN 05 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> <i>21218</i> | |

ST 00011

6

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00078 | |
|--|--|--|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) EVA GROCHOWINA | | | | 2. DATE OF DEATH MONTH JANUARY DAY 4, YEAR 1994 | | | | 3. TIME OF DEATH 5:20 AM | |
| 4. SOCIAL SECURITY NUMBER 218-05-7094 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 97 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sep 17, 1896 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) MARYLAND GENERAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH BALTIMORE CTIY | |
| 10a. STATE Maryland | | | | 10b. COUNTY - | | | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2334 Fleet Street | | | | 10f. ZIP CODE 21224 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0 | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker | | | | 16b. KIND OF BUSINESS/INDUSTRY - | | | | 17. FATHER'S NAME (First, Middle, Last) Andrzej Janka | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elybieta Soszynski | | | | 19a. INFORMANT'S NAME (Type/Print) Shawn R. Harby, Atty. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3911 Fait Ave. Balto. Md. 21224 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cemetery 1/6/94 | | | | 20c. LOCATION — City or Town, State Balto. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George A. Weber & Sons Inc. | | | | 22. NAME AND ADDRESS OF FACILITY George A. Weber & Sons Inc. 705 S. Ann St. Balto. Md. 21231 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION, SUSPECTED DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. URINARY TRACT INFECTION UROSEPSIS | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 27. DATE OF INJURY (Month, Day, Year) 28a. TIME OF INJURY 28b. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Ramonchito Menor, M.D. | | | | 29c. LICENSE NUMBER - | |
| 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAMONCHITO MENOR, M.D. c/o MARYLAND GENERAL HOSPITAL | | | | 31. DATE FILED (Month, Day, Year) JAN 05 1994 | |
| 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00079

| | | | | | |
|--|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ALBERT HOFFMAN | | | 2. DATE OF DEATH MONTH JUN DAY 1 YEAR 1994 | | 3. TIME OF DEATH 5:15P M |
| 4. SOCIAL SECURITY NUMBER 215-09-0260 | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 81 YRS. | 7. DATE OF BIRTH (Month, Day, Year) JUNE 6, 1912 | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE MARYLAND | 10b. COUNTY BALTIMORE | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8 DEAUVILLE CT, APT. 3B | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RETAIL STORE EXECUTIVE | | 16b. KIND OF BUSINESS/INDUSTRY RELIABLE STORES CORP. | |
| 17. FATHER'S NAME (First, Middle, Last) ISREAL HOFFMAN | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FRIEDA KATZENELL | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS MARY HOFFMAN | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 DEAUVILLE CT, APT. 3B BALTIMORE, MD 21208 | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) (ANSHE EMUNAH) AITZ CHAIM 1-3-94 | | 20c. LOCATION — City or Town, State BALTIMORE, MD | |
| 21. SIGNATURE OF PERSONAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. CEREBRAL VASCULAR ACCIDENT | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUMBER 9789 | | 29d. DATE SIGNED (Month, Day, Year) JAN 1, 1994 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAMES G. STUART DO. PGY-1 SINAI HOSPITAL HOUSESTAFF | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | 32. REGISTRAR'S SIGNATURE | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Pearl Johnson | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 4 1994 | | 3. TIME OF DEATH 8:05 AM | |
| 4. SOCIAL SECURITY NUMBER 214-50-3087 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct 1 1899 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Keswick Nursing Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 4208 Penhurst Avenue | |
| 10f. ZIP CODE 21215 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | | | 16b. KIND OF BUSINESS/INDUSTRY Homemaker | | | |
| 17. FATHER'S NAME (First, Middle, Last) Howard Morton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Plummer | | | |
| 19a. INFORMANT'S NAME (Type/Print) Atty Arthur L. Drager | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Light Street Suite 510 Balto, MD 21202 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE Arbutus Memorial Park 1/8 Baltimore County, MD | | | |
| 20c. LOCATION — City or Town, State Baltimore County, MD | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Herbert E. Nutter | | | |
| 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, MD 21216 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Arteriosclerotic coronary disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 3 1/2 years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | |
| 29c. LICENSE NUMBER D222334 | | | | 29d. DATE SIGNED (Month, Day, Year) 4 Jan 94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Nosy W Worsley 711 W 40th Street Balto 21210 | | | | 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | |
| 32. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Office of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-11-2010



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 94 00081 | |
|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | E. JACKSON, SR. | | 2. DATE OF DEATH | |
| MARVIN | | 1 MONTH 2 DAY 94 YEAR | | 3. TIME OF DEATH 2:23 P M | |
| 4. SOCIAL SECURITY NUMBER 216-52-0118 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 44 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 8-16-49 | | 8. BIRTHPLACE (State or Foreign Country) Md | | 9. COUNTY OF DEATH BALTO CITY | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO CITY | | 9c. COUNTY OF DEATH BALTO CITY | |
| 10a. STATE MO | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTO | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 596 YALE AVE. | | 10f. ZIP CODE 21229 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | 17. FATHER'S NAME (First, Middle, Last) Joseph M. Jackson Sr. | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Homes | | 19. INFORMANT'S NAME (Type/Print) Denise Jackson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 596 Yale Ave Balto, Md 21229 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Cem. 11/6/94 | | 20c. LOCATION — City or Town, State Elkridge, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | 22. NAME AND ADDRESS OF FACILITY March F.H. West 4300 Wabash Ave | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Intracranial hemorrhage. | | Approximate Interval Between Onset and Death 20 HRS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Hypertension. | | ? YES | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/2/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ZACHARIAS MAVROPHILOPOU | | 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | 31. SIGNATURE OF REGISTRAR [Signature] | |

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WILSON HILL

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94-0032-510
B.K.S

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00082

| | | | | | | | | | |
|---|--|---|--|---|--|---|---------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT C. KING JR. | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 02 94 | | 3. TIME OF DEATH 5:50 P M | | | |
| 4. SOCIAL SECURITY NUMBER 213-34-9907 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 56 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/26/37 | | 8. BIRTHPLACE (State or Foreign Country) MD | |
| 9a. FACILITY NAME (If not institution, give street and number) 4827 ORVILLE AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | 9c. COUNTY OF DEATH | | |
| 10a. STATE Md | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4827 Orville Avenue | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Printer | | 16b. KIND OF BUSINESS/INDUSTRY Printing | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert C. King, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Quail | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sharon Grosskopf | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12413 Glenbauer Road, Kingsville, Md. 21087 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 1/6 | | DATE | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Phillips Stacks</i> MO0550 | | 22. NAME AND ADDRESS OF FACILITY Moran-Ashton Funeral Home 3000 E. Baltimore Street, Balto, Md. 21224 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (First disease or condition resulting in death) → a. <i>Hypertensive Arteriosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i> | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) 01/03/1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Theodore M. King</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Jillie Davidson-Rodgers</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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March 2-1977 6 31

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00083

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Gustave Lambert | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 4, 1994 | | 3. TIME OF DEATH 9:10am M | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-20-3070 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 13, 1923 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 8302 Karl Ave. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH Baltimore | | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION Middle River | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10e. STREET AND NUMBER 3724 Red Grove Road | | 10f. ZIP CODE 21220 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 44-46 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) Auto Mechanic | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Auto Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Raymond Lambert | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Catherine Mattheu | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1718 Russett Court Forest Hill Md. 21050 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Zion Cemetery 1/6/94 | | 20c. LOCATION — City or Town, State Baltimore Md. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. TERMINAL CANCER b. METASTATIC LUNG CANCER c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donato A. Vargias Jr.</i> | | | | | | 29c. LICENSE NUMBER 217148 | | 29d. DATE SIGNED (Month, Day, Year) 1-5-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4706 Bonfano Rd 1 Balto, Md 21214 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Jake Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THIS HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00084

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DOROTHY MADELINE LONG | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 3, 1994 | | 3. TIME OF DEATH 6:45 A. | | | | | |
| 4. SOCIAL SECURITY NUMBER 218-64-7151 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 19, 1919 | | 8. BIRTHPLACE (State or Foreign Country) Westminster, Md. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 65 Hanover Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Reisterstown | | | 9c. COUNTY OF DEATH Baltimore | | | | |
| 10a. STATE Md. | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Reisterstown | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 65 Hanover Road | | | | 10f. ZIP CODE 21136 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) High School | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Benton Ebaugh | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosie Wagner | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Raymond L. Long Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65 Hanover Road Reisterstown, Md. 21136 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) All Saints Cemetery | | 20c. DATE 1/6/94 | | 20d. LOCATION — City or Town, State Reisterstown, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 11824 Reisterstown Road Reisterstown, Md. 21136 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Angina Sequitally flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Years | | | | | | | | Approximate Interval Between Onset and Death Years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER 225804 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Renzo Ricci M.D. 3125 Balto. Blvd. Finksburg, Md. 21048 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, confirm 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00085 | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Harry J. LOHR | | | | 2. DATE OF DEATH MONTH 1 DAY 2 YEAR 94 | | 3. TIME OF DEATH 12 36 M | | | | | |
| 4. SOCIAL SECURITY NUMBER 220-09-8687 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/16/04 | | 8. BIRTHPLACE (State or Foreign Country) Baltimore Co. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 7531 Belair Road | | | | 10f. ZIP CODE 21236 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Coke Oven Forman | | 16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel, Sparrows Pt. | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jospeh George Lohr | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Otto | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy D. Lohr | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7531 Belair Rd. Balto.. Md. 21236 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Belair memorial Gardens 1/5/94 | | DATE 1/5/94 | | 20c. LOCATION — City or Town, State Baltimore, md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lassahn Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Balto.. Md. 21236 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death days | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER N/A | | 29d. DATE SIGNED (Month, Day, Year) 1/8/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. Sikorski, MD, 9000 Franklin Square Drive, Baltimore, Maryland 21237 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00086

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SARAH LEE | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 2 1994 | | 3. TIME OF DEATH 1 20 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER 237-36-5790 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) APRIL 23, 1910 | | 8. BIRTHPLACE (State or Foreign Country) S.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTO | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 2607 SHIRLEY AVE | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) UNKNOWN | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNKNOWN | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN MCCELLAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA PAIGE | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) CORINE PULLIAM | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3010 OAKFORD AVE BALTO, MD 21215 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY 1694 | | 20c. DATE 1694 | | 20d. LOCATION — City or Town, State CATONSVILLE, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sola March</i> | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → pneumococcal sepsis Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST sinusitis | | | | | | | | Approximate Interval Between Onset and Death 6d 1mo | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. acute renal failure secondary to sepsis | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Linnea Boyev MD, PhD PGY-I</i> | | | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) JANUARY 2, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LINNEA BOYEV SINAI HOSPITAL | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Hudson-Randall</i> | | | | | | | |

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00087

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DMMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within _____ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and the State Dept. of Health and Human Hygiene prior to burial, cremation, or removal.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00088

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Anne B. Marshall | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 3, 1994 | | 3. TIME OF DEATH 7:00 P. M | |
| 4. SOCIAL SECURITY NUMBER 217-09-7658 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 92 YRS. | 7. DATE OF BIRTH (Month, Day, Year) Nov. 8, 1901 | | 8. BIRTHPLACE (State or Foreign Country) Iowa | |
| 9a. FACILITY NAME (If not institution, give street and number) 1608 Jennings Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie, MD. | | 9c. COUNTY OF DEATH Anne Arundel | |
| 10a. STATE Maryland | | | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Glen Burnie | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 1608 Jennings Road | | | | 10f. ZIP CODE 21061 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: X | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Bankson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unobtainable | | | |
| 19a. INFORMANT'S NAME (Type/Print) Richard D. Marshall, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1608 Jennings Rd., Glen Burnie, MD 21061 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore National Cem. 1/7 | | 20c. LOCATION — City or Town, State Baltimore, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry L. Kaufman</i> | | 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home 5695 Main St., Elkridge, MD 21227 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIO PULMONARY ARREST</u> Due to (or as a consequence of): b. <u>LUNG CANCER</u> Due to (or as a consequence of): c. <u>MALNUTRITION</u> Due to (or as a consequence of): d. <u>ANEMIA</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>LARGE PLEURAL EFFUSION</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. M. M. M.</i> | | | | 29c. LICENSE NUMBER D29748 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALIF MANESHANA, MD. 1307 CRAIN HWY GLEN BURNIE MD 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | 32. REGISTRAR'S SIGNATURE <i>John S. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate is required to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-0033-510

B.K.S

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00089

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES A. McLAUGHLIN | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 02 94 | | 3. TIME OF DEATH 4:38 P M | |
| 4. SOCIAL SECURITY NUMBER 224-22-5068 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jul 6 1924 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1701 EUTAW PLACE APT. #402 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1701 Eutaw Place | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER | | 16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel Corp. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Whitfield McLaughlin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Wilson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Carolyn Harris | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3019 Oakhill Avenue Baltimore, MD 21218 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veteran Cemetery/Garrison | | 20c. LOCATION — City or Town, State Owings Mills, MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vernon R. Bouley | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29a. SIGNATURE AND TITLE OF CERTIFIER Theodore Mc King, M.D. | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) 01/03/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore Mc King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | 32. REGISTRAR'S SIGNATURE John Benson | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 is marked, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00090

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary A. Mooney | | | | 2. DATE OF DEATH MONTH 11 DAY 1994 YEAR 94 | | 3. TIME OF DEATH 7:00 A M | |
| 4. SOCIAL SECURITY NUMBER 220-20-1005 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/29/27 | |
| 8. BIRTHPLACE (State or Foreign Country) Baltimore, Md. | | | | 9a. FACILITY NAME (If not institution, give street and number) 202 Linhigh Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 10. RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION 202 Linhigh Avenue | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 202 Linhigh Avenue | | | | 10f. ZIP CODE 21236 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Housekeeping | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Pletka | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Bosak | | | |
| 19a. INFORMANT'S NAME (Type/Print) Martin F. Mooney | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Linhigh Ave. Balto., Md. 21236 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem. 1/5/94 | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lassahn Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Constrictive fluid on myocardium</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>2nd degree atrioventricular conduction -</i> <i>apathy</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ASCVD and Abnormal Possible Epileptiform Abnormalities and/or degeneration</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29a. SIGNATURE AND TITLE OF CERTIFIER <i>Michael D. Hyde MD</i> | | | | 29c. LICENSE NUMBER D27693 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael D. Hyde MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Registrar, Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

94 00091

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) PAULINE MILLS | | | | 2. DATE OF DEATH MONTH 1 DAY 2 YEAR 94 | | 3. TIME OF DEATH 6002 AM | | | |
| 4. SOCIAL SECURITY NUMBER 230-46-4088 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs., last birthday) 61 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 6-18-32 | | 8. BIRTHPLACE (State or Foreign Country) N.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | | | |
| 10a. STATE md | | 10b. COUNTY Balto | | 10c. CITY, TOWN OR LOCATION Balto | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 7312 Fairbrook Rd Apt 3D | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Eley Ricks | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Roscoe | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marvin Venable | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7312 Fairbrook Rd Apt 3D Balto, md 21207 | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cem. 11/4/94 | | 20c. LOCATION — City or Town, State Catonsville, md | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lulu March | | | | 22. NAME AND ADDRESS OF FACILITY March FH - west 4300 Wabash Ave | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DIABETES MELLITUS DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death YEARS YEARS | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER E. P. Williams M.D. | | | | 29c. LICENSE NUMBER D11171 | | 29d. DATE SIGNED (Month, Day, Year) 1/2/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. P. Williams M.D. 405 FRED'K AVE - CATONSVILLE md 21228 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | REGISTRAR'S SIGNATURE Lulu March | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 20 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00092

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eula ^M Mitchell | | | | 2. DATE OF DEATH MONTH 1 DAY 1 YEAR 1994 | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER 220-30-3171 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-10-1916 | | 8. BIRTHPLACE (State or Foreign Country) N.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2501 Violet Avenue 904 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE Md | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 2501 Violet Avenue | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? U S A | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY Rogers Beauty Salon | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Clarence Allen | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Parthenia Patterson | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Juanita Ward | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4315 Reisterstown Road Baltimore, Md 21215 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park 1594 | | 20c. LOCATION — City or Town, State Randallstown, Md | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of the Lung DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death 6 mo | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Respiratory failure/Pneumonia Metastasis of Ca of lung to brain | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOK OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> O. Lawoyin | | | | 29c. LICENSE NUMBER 123724 | | 29d. DATE SIGNED (Month, Day, Year) 01-04-94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) OLUSEGUN O. LAWOYIN M.D., 2600 Liberty Heights Ave, Balt. MD. | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00093

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Gladys L. McCIure</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>01 02 94</i> | | 3. TIME OF DEATH <i>5:10 a.m.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>216-03-6490</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>87</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>5/26/06</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Howard County General Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Columbia</i> | | 9c. COUNTY OF DEATH <i>Howard County</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Baltimore</i> | | 10c. CITY, TOWN OR LOCATION <i>Randallstown</i> | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>3801 Schnaper Drive Apt. 235</i> | | | | 10f. ZIP CODE <i>21133</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12 Years</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Secretary</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Kernan Hospital HOSPITAL</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>William Pothast</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Elizabeth Agnes Bryant</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Joyce Tankersley</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6033 Snow Crystle Columbia, MD 21044</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Lake View Memorial Park 1-5 Sykesville, MD</i> | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John K. Byers</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Pneumonia</i> b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i> | | | | | | Approximate interval Between Onset and Death <i>Weeks</i> | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>B.H. Minchew, M.D.</i> | | | | 29c. LICENSE NUMBER <i>DO 9283</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>01/02/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>B.H. Minchew, M.D., 601 Old Annapolis Rd., Ellicott City, Md.</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 05 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

34 00000

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94-00094

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Everett Glenn Newton | | | | 2. DATE OF DEATH MONTH DAY YEAR 1 2 94 | | 3. TIME OF DEATH 11:45 AM | |
| 4. SOCIAL SECURITY NUMBER 213-68-8863 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 39 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4 -13-54 | |
| 9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Geriatric Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH Md. | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 206 Avondale Rd. | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Driver | | 16b. KIND OF BUSINESS/INDUSTRY Marshall Trash Remover | | | |
| 17. FATHER'S NAME (First, Middle, Last) Lenard Newton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lenora Custus | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lenora Newton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Avondale Rd., Baltimore, Md. 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park | | DATE 1/6 | | 20c. LOCATION — City or Town, State Randallstown, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | | | 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Head Injury with Complications DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 3/9/93 | | 28b. TIME OF INJURY 2:20A M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED Subject was pushed down and struck head on ground | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) in front of house | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 221 Sollers Pt. Rd. Baltimore Co., Md. | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Donald G. Wright MD | | | | 29c. LICENSE NUMBER OCME | | 29d. DATE SIGNED (Month, Day, Year) Re-issued 5/2/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald G. Wright, M.D., Deputy Chief, 111 Penn St., Baltimore, Md. 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) MAY 03 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, at least 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00095

| | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|---|--|--------------------------------------|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EVELYN ORMAN | | | | 2. DATE OF DEATH MONTH 1 DAY 1 YEAR 94 | | | | 3. TIME OF DEATH 12:25 P.M. | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-28-8453A | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH MONTH 2 DAY 6 YEAR 1908 | | 8. BIRTHPLACE (State or Foreign) MARYLAND | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS | | | | 9c. COUNTY OF DEATH ANNE ARUNDEL | | | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION SHADYSIDE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 5063 LERCH DRIVE | | | | 10f. ZIP CODE 20867 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALESPERSON | | | 16b. KIND OF BUSINESS/INDUSTRY TIE SHOP | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) BENJAMIN BERCOVITZ | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HANNAH | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS BEVERLY WISEMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6023 WOODCREST AVE. BALTIMORE, MD 21209 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SHAAREI ZION | | 20c. LOCATION — City or Town, State 1-4-94 ROSEDALE, MD | | 20d. DATE | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott M. Cutler | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215 | | | | | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA b. METASTATIC GASTRIC CANCER c. CHRONIC ACTIVE HEPATITIS d. SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | Approximate Interval Between Onset and Death 1 WEEK 1 YEAR | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Robert G. Gure MD | | 29c. LICENSE NUMBER D16364 | | 29d. DATE SIGNED (Month, Day, Year) 1/11/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE John Sanderford | | | | | | | | | | | |

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00096

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Richard PALASIK | | | | 2. DATE OF DEATH January 1, 1994 | | | | 3. TIME OF DEATH 5:45 a.m. | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-38-6559 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 18, 1940 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | | | | 9c. COUNTY OF DEATH Baltimore County | | | | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE Md. | | | | 10b. COUNTY Baltimore | | | | 10c. CITY, TOWN OR LOCATION Essex | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1020 Foxwood Lane | | | | | | 10f. ZIP CODE 21221 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR OATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clothing Factory | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Palasik | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Green | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Melvin Palasik | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 N. Marlyn Ave. Baltimore Md. 21221 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Rosary Cemetery | | | | OATE | | 20c. LOCATION — City or Town, State Dundalk Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE CONNELLY FUNERAL HOME | | | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 MAIZE AVE 21221 | | | | | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Small Cell Carcinoma of lung - metastatic DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Earl Hope MD | | | | 29c. LICENSE NUMBER D 39159 | | 29d. DATE SIGNED (Month, Day, Year) 1/1/94 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Earl Hope, MD Franklin Square Hospital Baltimore MD | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez | | | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHRISTINE B. POTZ | | | | 2. DATE OF DEATH MONTH JANUARY DAY 2ND YEAR 1994 | | 3. TIME OF DEATH 9:40 A M | |
| 4. SOCIAL SECURITY NUMBER 212-34-7810 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-10-1903 | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore -Towson | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 24 Acorn Circle | | | | 10f. ZIP CODE 21286 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Care Taker | | 16b. KIND OF BUSINESS/INDUSTRY Domestic | | | |
| 17. FATHER'S NAME (First, Middle, Last) Otto Potz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara Casper | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jennie Scheoeder | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6600 Danville Ave., Baltimore, Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory | | DATE | | 20c. LOCATION — City or Town, State Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins D00083 | | | | 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Baltimore, Md. 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEVERE HYPOXIC ENCEPHALOPATHY DUE TO (OR AS A CONSEQUENCE OF): CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST HYPERTENSION PERIPHERAL VASCULAR DISEASE HIP FRACTURE | | | | | | Approximate Interval Between Onset and Death TWO WEEKS TWO WEEKS 450 | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION PERIPHERAL VASCULAR DISEASE HIP FRACTURE | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER (#033) MD | | | | 29c. LICENSE NUMBER #033 | | 29d. DATE SIGNED (Month, Day, Year) JANUARY 2ND, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KOFI OWusu - BOATIEY, GOOD SAMARITAN HOSPITAL BALTIMORE | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | 32. REGISTRAR'S SIGNATURE Julia Hudson-Rodriguez | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00098

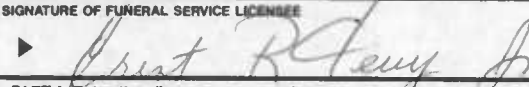
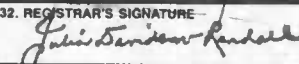
| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) LUDNE M. STREET | | | | 2. DATE OF DEATH MONTH 1 DAY 2 YEAR 94 | | 3. TIME OF DEATH 2:08A M | |
| 4. SOCIAL SECURITY NUMBER 424-64-9540 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 52 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-23-41 | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH N/A | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION N/A | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3615 Court Liegh Dr. | | | | 10f. ZIP CODE 21123 | | 10g. CITIZEN OF WHAT COUNTRY? US | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Highschool | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) Johnny webber | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Jordan | | | |
| 19a. INFORMANT'S NAME (Type/Print) Morris Street | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3615 Court Liegh Dr. Balto. MD 21123 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park | | 20c. LOCATION — City or Town, State Balto. Co. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 3/E Howell | | | | 22. NAME AND ADDRESS OF FACILITY Unity Funeral Home 108 W. North Ave. Balto. MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DIABETES MELLITUS DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death 4 YEARS 4 YEARS | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER E. P. Williamson | | | | 29c. LICENSE NUMBER D11171 | | 29d. DATE SIGNED (Month, Day, Year) 1/2/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. P. Williamson 405 Fred Ave - CATONSVILLE, MD 21228 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00099

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elizabeth Stewart | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 03 94 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 214-40-5174 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug 30 1903 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9. COUNTY OF DEATH | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2406 West Lafayette Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2406 West Lafayette Avenue | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Balto. City Public Sch | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frederick Jenkins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Smith | | | |
| 19a. INFORMANT'S NAME (Type/Print) Earlene E. Jenkins | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4705 6th Place NE Washington, DC 20017 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 1/6 Baltimore Co., MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, MD 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory arrest DUE TO (OR AS A CONSEQUENCE OF): b. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. and asthma DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus atherosclerosis | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Sandra M Walden MD | | | | 29c. LICENSE NUMBER D27759 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SANDRA M WALDEN MD 611 PARK AVE, 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1/3 JAN 05 1994 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ST. PAUL BOND



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00100

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FRANKLIN SUNSTROM | | | | 2. DATE OF DEATH MONTH 1 DAY 3 YEAR 94 | | 3. TIME OF DEATH 03:18 AM | |
| 4. SOCIAL SECURITY NUMBER 212-05-7119 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 79 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 | 7. DATE OF BIRTH (Month, Day, Year) 07/12/14 | |
| 9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH Maryland | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 113-15th Avenue | | | | 10f. ZIP CODE MD 21225 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black (White) etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Traffic Manager | | 16b. KIND OF BUSINESS/INDUSTRY Baltimore Gas & Electric | | | |
| 17. FATHER'S NAME (First, Middle, Last) Elmer Sunstrom | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Rowan | | | |
| 19a. INFORMANT'S NAME (Type/Print) Franklin Sunstrom | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 452 Nolcrest Road Glen Burnie, Maryland 21061 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | 20c. DATE 1/6 | | 20d. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anna M Zroniewski</i> | | | | 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Right upper lobe viral pneumonia, COPD b. Angioneurotic edema c. Myocardial infarction d. Hx of partial gastrectomy of PUD, GI bleeding | | | | | | | Approximate interval between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dr SOE MD | |
| 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARBOR Hospital | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | 32. REGISTRAR'S SIGNATURE <i>John Sanderford</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED
JAN 10 1964

U.S. AIR FORCE

RECEIVED
JAN 10 1964

1

94-0001-510

blh

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00101

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) Kirk A. Thompson | | | | 2. DATE OF DEATH MONTH 01 DAY 01 YEAR 1994 | | 3. TIME OF DEATH 0450 M | |
| 4. SOCIAL SECURITY NUMBER 212-33-1742 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 20 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7/22/1973 | |
| 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 9 Leafydale Court | | | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 1 Year | | 15b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Delroy Thompson | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Paulette Munro | | | |
| 19a. INFORMANT'S NAME (Type/Print) Paulette A. Thompson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Leafydale Court Baltimore, Md 21208 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Woodlawn Cemetery | | DATE 1894 | | 20c. LOCATION — City or Town, State Baltimore, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE W. Edwin Edmond | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Head and Chest Injuries DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 01 01 1994 | | 28b. TIME OF INJURY 0020 M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED Driver in auto/auto impact | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) on street | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) W. Northern Pkwy. & Wabash Avenue | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ramon Locke MD | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01 01 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Ramon Locke, MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. SIGNATURE OF REGISTRAR Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00102 | |
|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Robert T. Webb</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>7</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>8:45</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>425-38-6751</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>63</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 12, 1930</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Mississippi</i> | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Carroll County General Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Westminster</i> | | 9c. COUNTY OF DEATH <i>Carroll</i> | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>Frederick</i> | | 10c. CITY, TOWN OR LOCATION <i>Emmitsburg</i> | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER <i>17041 Bullfrog Road</i> | | | | 10f. ZIP CODE <i>21727</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>Korean</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>1 Year</i> College (1-4 or 5+) <i>1 Year</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Mechanic</i> | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) <i>William M. Webb</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Etta King</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Sarah Jane Webb</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>17041 Bullfrog Road Emmitsburg, MD 21727</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Prospect U.M. Ch. Cemetery 1/4</i> | | 20c. LOCATION — City or Town, State <i>Mt. Airy, Maryland</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Burrier-Queen Funeral Directors, P.A. 21784 1212 West Old Liberty Road Winfield, MD</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Atherosclerotic Cardiovascular Disease</i> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard A. Jones MD ME</i> | | | | 29c. LICENSE NUMBER <i>D05905</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>Jan 5 94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Richard A. Jones MD Carroll County General Hosp.</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 05 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

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1. The first part of the report is a general description of the project and its objectives.

2. The second part of the report is a detailed description of the methodology used in the study.

3. The third part of the report is a discussion of the results of the study and their implications for future research.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00103 | |
|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Willie J. White</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>1</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>1040 A.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>214-40-214</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>50</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year) <i>12/27/42</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Balto. MD</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH <i>N/A</i> | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>N/A</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>4001 Belview Ave.</i> | | | | 10f. ZIP CODE <i>21215</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>Δ</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th</i> College (14 or 5+) <i>N/A</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Laborer</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Hydro-Conduit</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Ollie White</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lucille Rantin</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>LUCILLE White</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4001 Belview Ave. Balto. MD 21215</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <i>Cedar Hill</i> | | DATE <i>1/7/94</i> | | 20c. LOCATION — City or Town, State <i>Glen Burnie, MD</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J.E. Howell, Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Unity Funeral Home 108 W. North Ave. Balto. MD 21201</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. anoxic encephalopathy</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>b. pneumonia & sepsis</i> c. d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael T. Pullay MD</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>1/1/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael T. Pullay MD Sinai Hospital</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 05 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John S. ...</i> | | | |

00100 82

11000

47

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00104

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JACKIE DECOASTER WILLIS | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 3 1994 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 226-72-8572 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 44 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug 16 1949 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9. COUNTY OF DEATH | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 5616 Northwood Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5616 Northwood Drive | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Line Worker | | 16b. KIND OF BUSINESS/INDUSTRY Merry-Go-Round Indust. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Lowe | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Ball | | | |
| 19a. INFORMANT'S NAME (Type/Print) Roger E. Willis | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5616 Northwood Drive Baltimore, MD 21212 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Zion Baptist Church Cem-8 Kinsale, Va | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Colon Cancer DOE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Metastatic Colon Cancer b. DOE TO (OR AS A CONSEQUENCE OF): c. DOE TO (OR AS A CONSEQUENCE OF): d. DOE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles A. Padgett</i> | | | | 29c. LICENSE NUMBER 315546 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles Padgett and 5601 Loch Raven Blvd., Baltimore MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

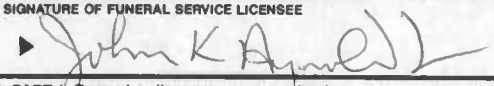

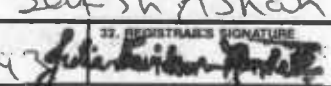
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10:00

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|--|--|--|-------------------------------------|---|-----------------------------------|---|--|
| 1. FOR REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00105 | |
| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | |
| CHARLES WALTER WARFIELD | | MONTH DAY YEAR Jan 3, 1994 | | | | M | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRTHPLACE (State or Foreign Country) | |
| 213-12-6510A | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | YRS. | MONTHS DAYS | HOURS MIN. | Month, Day, Year Sept 12, 1914 | Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | 9c. COUNTY OF DEATH | |
| 7008 Hampton Circle | | | Mt. Airy | | | Carroll County | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | |
| Maryland | | Carroll Co. | | Mt. Airy | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| 7008 Hampton Circle | | | 21771 | | USA | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | Mechanic | | US Government | | | |
| 6 years | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| Charles Allen Warfield | | | | Anna Palmer | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| Mrs. Patricia L. Barnhart | | | | 2383 Braddock Rd. Mt. Airy, MD 21771 | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | Poplar Springs Cem. | | 1-6 | | Poplar Springs, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | |
|  | | | | Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | 8 m with | |
| Stomach cancer | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? | |
| | | | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| | | | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH (Check only one) | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | | | | |
| 29a. CERTIFIER (Check only one) | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |  | | | | | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| | | D36147 | | 1-4-93 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| Soutih Ashah 1004 Soutef Littleton Pike Westmont md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | 32. REGISTRAR'S SIGNATURE | | | | | |
| JAN 05 1994 | |  | | | | | |

20100 JB

305-222-2222 11/11/00

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The funeral director certifies that the death certificate is being filed within 72 hours after death, and that the death certificate is being filed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00106 | | | |
|---|--|--|---|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) HAROLD L. YOFFE | | | | 2. DATE OF DEATH MONTH JANUARY DAY 1, YEAR 1994 | | | | 3. TIME OF DEATH 12:50 PM | | | |
| 4. SOCIAL SECURITY NUMBER 219-16-7156 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 70 YRS. | 7. DATE OF BIRTH MONTH MAY DAY 17, YEAR 1923 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) STINAT HOSPITAL RESIDENCE OF DECEDENT | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3201 OLD POST DRIVE, APT. 2 | | | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OPTICIAN | | 16b. KIND OF BUSINESS/INDUSTRY TOWN OPTICAL | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) BENNE YOFFE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FANNE BRILL | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS BEATRICE YOFFE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3201 OLD POST DRIVE, APT. 2 BALTIMORE, MD 21208 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BETH TFILOH | | 20c. DATE 1-3-94 | | 20d. LOCATION — City or Town, State BALTIMORE, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Ischemic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. CABG x 2; Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): d. Cerebrovascular Disease Stroke Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1.2.94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

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THE DEATH CERTIFICATE OF A PERSON DIED IN A HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00107 | |
|--|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Mary M. ZIEMANN | | | | 2. DATE OF DEATH MONTH January DAY 3, 1994 YEAR | | | | 3. TIME OF DEATH 7:55 A M | |
| 4. SOCIAL SECURITY NUMBER 220-24-7963 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 29, 1910 | | 8. BIRTHPLACE (State or Foreign Country) OHIO | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | | | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 310 Riverside Road | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12th College (1-4 or 5+) : | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesperson | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Peter Morrell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie A. Rossi | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Frederick Ziemann | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Riverside Road Baltimore MD. 21221 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Cemetery 1/7/94 Bel Air Md. | | | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Connelly Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinomatosis, primary squamous cancer of lungs Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Raymundo Magno | | | | 29c. LICENSE NUMBER D09350 | |
| 29d. DATE SIGNED (Month, Day, Year) 1-3-94 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Raymundo Magno 7811 Wise Ave. Baltimore, Maryland 21222 | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 05 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson | | | | | |

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Handwritten signature

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00108

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|---------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DOROTHY M. ZIMMERER | | | | 2. DATE OF DEATH MONTH 1 - DAY 3 - YEAR 94 | | 3. TIME OF DEATH 07:28 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-44-2533 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-15-1903 | | 8. BIRTHPLACE (State or Foreign Country) MD. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) MERCY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO. | | | 9c. COUNTY OF DEATH | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTO. | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 830 WEST 40TH ST. | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12yrs. | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 15b. KIND OF BUSINESS/INDUSTRY HOMEMAKER | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) MUNROE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. VERNON G. CRUDGE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 EAST 69TH ST. N.Y., N.Y. 10021. | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY 1/5 | | 20c. LOCATION — City or Town, State BALTO., MD. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William R. Davis, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASYSTOLE DUE TO (OR AS A CONSEQUENCE OF): b. Atrial dysrhythmia DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death SECONDS YEARS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Chronic lung disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) N/A | | 28b. TIME OF INJURY N/A | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED N/A | | | |
| 28a. PLACE OF INJURY — As home, farm, street, factory, office building, etc. (Specify) N/A | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John E. Linder | | | | 29c. LICENSE NUMBER D34952 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print) 5444 Belair Rd Baltimore MD 21206 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1 JAN 8 5 1994 | | | | 32. REGISTRAR'S SIGNATURE John E. Linder | | | | | | | |

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00109

REG. NO.

| | | | | | | | |
|--|--|--------------------|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>William Anderson</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>Jan. 3, 1994</i> | | 3. TIME OF DEATH <i>12:43 am</i> | |
| 4. SOCIAL SECURITY NUMBER <i>220-03-3647</i> | | 5. SEX <i>M</i> | | 6. AGE (In yrs. last birthday) <i>77</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>12/17/16</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Bon Secours Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i> | | 9c. COUNTY OF DEATH <i>Baltimore</i> | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY <i>Baltimore</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | |
| 10d. INSIDE CITY LIMITS? <i>1</i> YES <i>2</i> NO | | | | 10e. STREET AND NUMBER <i>1715 Brunt St</i> | | 10f. ZIP CODE <i>21217</i> | |
| 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 11. MARITAL STATUS <i>3</i> Widowed <i>4</i> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> YES <i>2</i> NO <i>U W I</i> | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> YES <i>2</i> NO | | | | 14. RACE — American Indian, Black, White, etc. <i>Black</i> | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i> | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Longshoreman</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>STA</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Unknown</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Unknown</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Linda Rogers</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1715 Brunt St Baltimore Md. 21217</i> | | | |
| 20a. METHOD OF DISPOSITION <i>1</i> Burial <i>2</i> Cremation <i>3</i> Removal from State <i>4</i> Donation <i>5</i> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <i>Garrison Forest Burial Home</i> | | | |
| 20c. LOCATION — City or Town, State <i>Balto. Co. Md.</i> | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY <i>Joseph L. Russ Funeral Home</i> | | | | 22. ADDRESS OF FACILITY <i>2252 W. North Ave. Balto. Md. 21216</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration Pneumonia</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension, C.V.A.; Carcinoma Prostate</i> <i>Sp BK Amputation</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <i>1</i> YES <i>2</i> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1</i> YES <i>2</i> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1</i> YES <i>2</i> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA OTHER: <i>4</i> Nursing Home <i>5</i> Residence <i>6</i> Other (Specify) | | | |
| 27. MANNER OF DEATH <i>1</i> Natural <i>5</i> Pending Investigation <i>2</i> Accident <i>6</i> Could not be determined <i>3</i> Suicide <i>7</i> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) <i>1-3-93</i> | | | |
| 28b. TIME OF INJURY <i>M</i> | | | | 28c. INJURY AT WORK? <i>1</i> YES <i>2</i> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <i>1</i> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER <i>D17537</i> | | | |
| 29d. DATE SIGNED (Month, Day, Year) <i>1-3-93</i> | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>DARSHAN S. SALUJA MD 1600 MT Royal Ave, Balto 21217</i> | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 06 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00110

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDNA BOYD Edna Mae Boyd | | | | 2. DATE OF DEATH MONTH 1 DAY 3 YEAR 94 | | 3. TIME OF DEATH 9:00 P.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 169-34-9574 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5 18 31 | | 8. BIRTHPLACE (State or Foreign Country) S. Carolina Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Church Home Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2625 Round Road | | | | 10f. ZIP CODE 21225 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th grade | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Rivers | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Viola Hanibal | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Viola Boyd | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21231 207 N. Wolfe Street Baltimore, Maryland | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery | | DATE 1/8/94 | | 20c. LOCATION — City or Town, State Catonsville, Md | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Geray Harris | | | | 22. NAME AND ADDRESS OF FACILITY 1701 McCulloh St Chatman-Harris F/H Baltimore, Md 21217 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COLUMBUS BILLY DISEASE MALIGNANT CAEXEMIA MALIGNANT PLEURAL EFFUSION | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Shirley A. M.D. | | | | 29c. LICENSE NUMBER D38882 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KHALID K. ALTALIB, Church Home Hospital, Baltimore MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 6 1994 | | | | 32. REGISTRAR'S SIGNATURE Justinian R... | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00111

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|---------------------|--|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROYAL FULTON BROWN | | | | 2. DATE OF DEATH MONTH DAY YEAR January 4, 1994 | | 3. TIME OF DEATH 2:37 A M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-18-9958 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04-04-21 | | 8. BIRTHPLACE (State or Foreign Country) VA | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | 9c. COUNTY OF DEATH | | | | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10e. STREET AND NUMBER 939 MCALEER COURT | | 10f. ZIP CODE 21202 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | 15b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE BROWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA WHITE | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) HAZEL BARTEE/FLOYD NEAL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 939 MCALEER CT. BALTIMORE, MD 21202 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 1/8 | | 20c. LOCATION — City or Town, State LANDSDOWNE. MD. | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE BETTS FUNERAL HOME | | | | 22. NAME AND ADDRESS OF FACILITY 1129 N. CAROLINE ST BALTIMORE, MARYLAND 21213 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Malnutrition</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Widely Metastatic Gastric Carcinoma</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | Approximate interval Between Onset and Death 5 days 1 year | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>chronic obstructive pulmonary disease</u> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Jeremy Rich MD | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/4/93 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeremy Rich, MD Johns Hopkins Hospital, Tower 110, Baltimore MD 21287 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Anderson-Randall | | | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: Item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 001121

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Carrie Clark | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 1 1994 | | 3. TIME OF DEATH 7:30 A.M. | |
| 4. SOCIAL SECURITY NUMBER 220-18-6222 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 50 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Apr 29, 1943 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9. COUNTY OF DEATH | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Liberty Med Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2547 W. North Ave. | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Jones | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Sheila Lee | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2547 W. North Ave. Balt. Md 21216 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) Zion Cem | | 20c. LOCATION — City or Town, State Balt. Co. Md | | 20d. DATE 1/1/94 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | | | | 22. NAME AND ADDRESS OF FACILITY Joseph H. Russ Funeral Home 2252 W. North Ave. Balt. Md 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septic / Cardiogenic Shock DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lung Mass Acute Renal Failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER George E. Wicks III M.D. | | | | | |
| 29c. LICENSE NUMBER D41365 | | 29d. DATE SIGNED (Month, Day, Year) Jan 1, 1994 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George E. Wicks III M.D. 2600 Liberty Heights | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00113

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DALLAS CHRISTIAN | | | | 2. DATE OF DEATH MONTH 01- DAY 02- YEAR 94 | | 3. TIME OF DEATH n/a | |
| 4. SOCIAL SECURITY NUMBER 218- 07- 4096 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84-82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11- 23- 09 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2511 E. CHASE STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH n/a | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2511 E. CHASE STREET | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 TH College (1-4 or 5+) n/a | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) n/a | | 16b. KIND OF BUSINESS/INDUSTRY BETHLEHEM STEEL | | | |
| 17. FATHER'S NAME (First, Middle, Last) ROBERT CHRISTIAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BELLE CHAMBERS | | | |
| 19a. INFORMANT'S NAME (Type/Print) ROSA CHRISTIAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2511 E. CHASE STREET, BALTIMORE, MARYLAND 21213 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or facility and date) ARBUTUS MEMORIAL PARK | | 20c. DATE OATE | | 20d. LOCATION — City or Town, State ARBUTUS, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Possible Acute MI Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. w/ 9 BP. Hx D. H. H. C.R.H. C.H. c. Cervical embolus spinal chord d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D14221 | | 29d. DATE SIGNED (Month, Day, Year) 1.5.94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1. A. F. H. 223 E. Blvd BALT and 21221 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 6 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James William Cox, Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 2, 1994 | | 3. TIME OF DEATH 12:00 P M | |
| 4. SOCIAL SECURITY NUMBER 215-18-5689 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 30, 1921 | |
| 9a. FACILITY NAME (If not institution, give street and number) 4010 Compass Run Lane | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Hampstead | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION HAMPSTEAD | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4010 Compass Run Lane | | | | 10f. ZIP CODE 21074 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self-Employed Contractor | | 16b. KIND OF BUSINESS/INDUSTRY Building & Construction | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Gregory Cox | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Gutberlet | | | |
| 19a. INFORMANT'S NAME (Type/Print) James William Cox, Jr. | | | | 19b. MAILING ADDRESS 2907 Cresmont Ave. Baltimore, Md. 21211 2707 Cresmont Avenue, Baltimore, MD 21211 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. JAN | | 20c. LOCATION — City or Town, State Catonsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, MD 21093 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Coronary Artery / mycardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | b. <i>Seven PUD + CAD.</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D40121 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dale Buchbinder, M.D. 6565 North Charles Street, Baltimore, Maryland 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE John Anderson-Randall | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P. 0000 68760, 0000

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR THE PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00115

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RAYMOND E. DEAVERS | | | | 2. DATE OF DEATH MONTH 1 DAY 2 YEAR 94 | | 3. TIME OF DEATH 3:00 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER 718 18 8216 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/9/13 | | 8. BIRTHPLACE (State or Foreign Country) W. Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Mercy Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3213 Leverton Ave. | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) — | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Soldier | | | | 15b. KIND OF BUSINESS/INDUSTRY Beth Steel | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) DEAVERS | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) FRANK MAZZOLA | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3411 Mt. Pleasant Ave. Balt. MD 21224 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH CEM. 4/4/94 Balt. Maryland | | 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH N ZANNINO JR. F.H. 21224 263 S. CONKLING ST. Balt. MD | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): INTESTINAL OBSTRUCTION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) N/A | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER K. Paul Boyev MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1-3-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K. PAUL BOYEV MD Mercy Hospital 301 St. Paul St. Balt. MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00116 | |
|--|--|--|---|---|--------------------------------|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) John Dew | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 5, 1994 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 214-20-1218 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Feb. 18, 1926 | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION MONKTON | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 16350 Matthews Road | | | | 10f. ZIP CODE 21111 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4+ | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Survey (Land) | | 16b. KIND OF BUSINESS/INDUSTRY Land Design (Topography) | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edgar H. Dew | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Henrietta Ester Casler | | | |
| 19a. INFORMANT'S NAME (Type/Print) Nancy Lee Dew | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15920 Carroll Rd., Monkton, MD 21111 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Immanuel Episcopal Church JAN 6 | | 20c. LOCATION — City or Town, State Glencoe, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lowell M. Lemmon</i> | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, MD 21093 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Intracerebral hemorrhage</i> Approximate Interval Between Onset and Death <i>3 days</i> | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): <i>years</i> | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ASCD & peripheral vascular disease</i> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Kaplan MD</i> | | | | 29c. LICENSE NUMBER <i>D19155</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/6/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Mark Kaplan, 16918 York Road, Monkton, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | | | |

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00117

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH DAVID | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 05:00 AM | |
| 4. SOCIAL SECURITY NUMBER 578 16 0153 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05 15 16 | |
| 9a. FACILITY NAME (If not institution, give street and number) BON SECOURS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH CITY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY CITY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER CAMDEN YARDS REHAB. CTR. | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Penn. Railroad | | 15b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Thomas Davis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nettie Graham | | | |
| 19a. INFORMANT'S NAME (Type/Print) Bertha Anthony | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1639 N. Fulton Avenue Balto., MD. 21217 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arrat Cemetery 1/8/94 | | 20c. LOCATION — City or Town, State MT. Airy N.C. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bertha Hector | | | | 22. NAME AND ADDRESS OF FACILITY CFSP #281 E.L. Phillips F/H 1721-27 N. Monroe ST. Balto., MD. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | ASPIRATION PNEUMONITIS (Respiratory) DUE TO (OR AS A CONSEQUENCE OF): Longstanding heart failure with peripheral edema DUE TO (OR AS A CONSEQUENCE OF): Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): Serious disorder | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | Stroke Chronic pancreatitis Stomach tube insertion | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER D18711 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bernard J. Gunkle, MD - 3000 W. Baltimore St, Balto, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form must be completed by the attending physician within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00118 | |
|---|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Willie Davis</i> Willie Davis | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>3</i> YEAR <i>94</i> | | | | 3. TIME OF DEATH <i>5:17 P M</i> | |
| 4. SOCIAL SECURITY NUMBER 237-03-0480 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/1/1923 | | 8. BIRTHPLACE (State or Foreign Country) N. CAROLINA | |
| 9a. FACILITY NAME (If not institution, give street and number) HOWARD COUNTY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH COLUMBIA | | | | 9c. COUNTY OF DEATH | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY COLUMBIA | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3124 W. SPRINGS DRIVE | | | | 10f. ZIP CODE 21043 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 3/4/43 1/5/46 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) SIRLATHEON BAILEY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MAGGIE DAVIS | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) LOUISE B. DAVIS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3124 W. SPRINGS AVENUE COLUMBIA, MD 21043 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VET. CEM. | | DATE | | 20c. LOCATION — City or Town, State OWINGS MILLS, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Diabetes Mellitus</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>Days</i> <i>Chronic</i> <i>Chronic</i> | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Lewis, MD</i> | | 29c. LICENSE NUMBER D22856 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>J. Lewis, MD 11055 Little Patuxent Pk, Greenbelt, Md</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John S. ...</i> | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) PEARL LAVENIA EDWARDS | | | | 2. DATE OF DEATH MONTH DAY YEAR 1 03 1994 | | 3. TIME OF DEATH 9:20 P. M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-26-4078 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-17-1900 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 342 MARLEY NECK ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | | | 9c. COUNTY OF DEATH | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION GLEN BURNIE | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 342 MARLEY NECK ROAD | | | | 10f. ZIP CODE 21060 | | 10g. CITIZEN OF WHAT COUNTRY? USA. | | | | | |
| 11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM PITTS | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) AMELIA TURNER | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARY STEWART | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 342 MARLEY NECK ROAD, GLEN BURNIE, MARYLAND 21060 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HALLS CHURCH CEMETERY | | DATE | | 20c. LOCATION — City or Town, State GLEN BURNIE, MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles D. Brown</i> | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTO. MD. 21223 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arterio Sclerosis & Cardio-Vascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Christopher deBorja M.D.</i> | | | | 29c. LICENSE NUMBER D42820 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christopher deBorja 3708 Mountain Rd., Pasadena MD 21122 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 0 6 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: The funeral certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is initiated for item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00120

| | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Isreal Engram | | | | 2. DATE OF DEATH MONTH 14 DAY 94 YEAR | | 3. TIME OF DEATH 11:45 am | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-58-2470 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 41 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-17-52 | | 8. BIRTHPLACE (State or Foreign Country) MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number) (Home) 1416 Ward Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1416 Ward Street | | | | 10f. ZIP CODE 21230 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: AFR. AMERICAN | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JESSE ENGRAM | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) PURNELL ENGRAM | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Warnette Engram | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1416 Ward St. Baltimore, Md. 21230 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Baltimore, Md. 21217 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Head and Neck Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Severe Peripheral Vascular Disease with Ischemic Necrosis of Leg.</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Suzanne R. DeLeonard</u> | | | | 29c. LICENSE NUMBER 031351 | | | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Purnell DeLeonard 3001 SHANOVER ST, Baltimore Md. 21225</u> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <u>John Sanders-Randall</u> | | | | | | | |

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7

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00121

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Seymour Freedman | | | | 2. DATE OF DEATH MONTH 1 DAY 3 YEAR 94 | | 3. TIME OF DEATH 5:31 P M | |
| 4. SOCIAL SECURITY NUMBER 189 05 3524 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 9, 1911 | |
| 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | 9c. COUNTY OF DEATH Montgomery | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2445 Lyttonsville Road | | | | 10f. ZIP CODE 20910 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Public Relations | | 16b. KIND OF BUSINESS/INDUSTRY Self-employed | | | |
| 17. FATHER'S NAME (First, Middle, Last) Max Freedman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Berkowitz | | | |
| 19a. INFORMANT'S NAME (Type/Print) Estelle Freedman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same address as #10 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of institution, cemetery, etc.) King David Memorial Gardens | | DATE 1-4-94 | | 20c. LOCATION — City or Town, State Falls Church, Va. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church, Va. 22046 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Heart Disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 15 YEARS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Lung Disease chronic cerebral vascular disease chronic Atrial Fibrillation | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D25808 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Herman B Segal 1023 Georgia Ave Silver Spring Md 20902 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

301-681-9095
Dr. Segal - not in
yesterday Sanet

1890-92

ADAMS & CO

W. L. Adams & Co
New York

W. L. Adams & Co

W. L. Adams & Co

W. L. Adams & Co

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00122

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|---------------------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Henry T. Gruber | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 12:07 A.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 137-03-0195 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) March 12, 1902 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Fairhaven Life Care Community | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Sykesville | | | 9c. COUNTY OF DEATH Carroll County | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE Maryland | | 10b. COUNTY Carroll County | | 10c. CITY, TOWN OR LOCATION Sykesville | | | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 7200 Third Avenue | | 10f. ZIP CODE 21784 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clergy | | 16b. KIND OF BUSINESS/INDUSTRY Episcopalian Clergy | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Harry Gruber | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Yerkes | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Mary H. Gruber | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) C-76 7200 Third Avenue Sykesville, MD 21784 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Serv. Jan. 5, 1994 Hampstead, MD | | 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian D. Haight | | | | 22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PROSTATE CANCER. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death 5 years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Chronic obstructive pulmonary disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER William TIAN MD | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William TIAN MD 1645 Liberty Rd Eldersburg MD 21784 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | |

1950

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00123

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Anna D. Holley</u> | | | | 2. DATE OF DEATH MONTH <u>1</u> DAY <u>1</u> YEAR <u>1994</u> | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER <u>218-76-4761</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>32</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>8-2-1961</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Seton Manor</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u> | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <u>Md</u> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <u>Baltimore</u> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>1039 Sir Ann Street</u> | | | | 10f. ZIP CODE <u>21223</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10th</u> College (1-4 or 5+) <u>College</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Dennis Holley</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary Jane Thomas</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Dennis Holley</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2552 Harlem Avenue Baltimore, Md 21216</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Arbutus Memorial Park</u> <u>1794</u> | | 20c. LOCATION — City or Town, State <u>Arbutus, Md</u> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Bladys Wanes</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>March F/H West</u> <u>4300 Wabash Avenue</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Renal Failure</u> a. DUE TO (OR AS A CONSEQUENCE OF): <u>AIDS</u> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CMV retinitis</u> <u>Anasarca</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Claire Beiser, MD</u> | | | | 29c. LICENSE NUMBER <u>D43959</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>1/6/94</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Claire Beiser, MD</u> <u>Box 165, 225 Greene, Balto., 21201</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 06 1994</u> | | | | 32. REGISTRAR'S SIGNATURE <u>John Davidson-Rudolph</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00124 | |
|--|--|---|---|---|--|--|---|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES HEYWOOD JR. | | | | 2. DATE OF DEATH MONTH 1 DAY 1 YEAR 94 | | 3. TIME OF DEATH 3:15 P M | |
| 4. SOCIAL SECURITY NUMBER 213-64-5479 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 38 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 10-05-1955 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| 10a. STATE MD. | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3308 WINDSOR AVENUE | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES HEYWARD SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BERNICE HEYWOOD | | | |
| 19a. INFORMANT'S NAME (Type/Print) BERNICE HEYWARD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3308 WINDSOR AVENUE, BALTIMORE, MARYLAND 21216 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY, INC. | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. INFECTIOUS ENDOCARDITIS DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate interval Between Onset and Death 21 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. INTRAVENOUS SUBSTANCE ABUSE DUE TO (OR AS A CONSEQUENCE OF): | | | | | 10 days |
| | | c. ASPIRATION PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PREVIOUS CEREBROVASCULAR EVENT | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER L. Magalong MD | | | | 29c. LICENSE NUMBER UMMS 6799 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LESLIE MAGALONG MD 22 SOUTH GREENE ST. BALTIMORE, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 0 6 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00125 | | | |
|---|--|--|--|---|--|---------------------------------------|--|--|--|--------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | |
| GERTRUDE COOPER HORLICK | | | | MONTH DAY YEAR JAN 1 1994 | | | | 6:20 A M | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | 9. COUNTY OF DEATH | |
| 120-03-9929 | | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 79 YRS. | | MONTHS DAYS HOURS MIN. MAY 28 1914 | | MASSACHUSETTS | | MONTGOMERY | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| NATIONAL NAVAL MEDICAL CENTER | | | | BETHESDA | | | | MONTGOMERY | | | |
| 10a. STATE | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION | | | |
| VIRGINIA | | | | ARLINGTON | | | | ARLINGTON | | | |
| 10d. INSIDE CITY LIMITS? | | | | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 3004 N. STUART STREET | | | | 22207 | | | |
| 11. MARITAL STATUS | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) | | | |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 17. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | | | PSYCHOLOGIST-CLINICAL | | | | PRIVATE | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | 19. INFORMANT'S NAME (Type/Print) | | | |
| SAMUEL COOPER | | | | HINDE UNAVAILABLE | | | | REUBEN S. HORLICK | | | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | 20a. METHOD OF DISPOSITION | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | |
| 3004 N. STUART STREET, ARLINGTON VA 22207 | | | | 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | KING DAVID MEMORIAL GARDEN 1-4-94 FALLS CHURCH, VA. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | |
| | | | | IVES-PEARSON FUNERAL HOMES FALLS CHURCH, VA 22046 | | | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | a. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | b. HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| | | | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| | | | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | 27. MANNER OF DEATH | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY | | | | 28c. INJURY AT WORK? | | | |
| | | | | M | | | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| | | | | | | | | 2 JAN 94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | |
| J.D.MAGUIRE, LT, MC, USNR | | | | JAN 06 1994 | | | | | | | |
| NATIONAL NAVAL MEDICAL CENTER | | | | | | | | | | | |
| BETHESDA MD 20889-5600 | | | | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | REG. NO. | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Junius Jones Jr. | | | | 2. DATE OF DEATH MONTH 1 DAY 03 YEAR 94 | | 3. TIME OF DEATH 1100 P M | | | |
| 4. SOCIAL SECURITY NUMBER 237-14-1569 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 73 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 3-12-20 | 8. BIRTHPLACE (State or Foreign Country) Georgia | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) BON SECOURS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Md | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 2111 W. Mulberry Street | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Spray Painter | | 16b. KIND OF BUSINESS/INDUSTRY Auto Manufacturer | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Junius Jones Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Lee Harper | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Eunice Jones | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111 W. Mulberry St. Balto Md. 21223 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) London Park Cem 1814 Baltimore, Md | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Cable Funeral Service 5502 Winner Ave Balto Md 21215 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → possible arrhythmia DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Marked cardiomegaly DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - HTN - diabetes mellitus | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D39127 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) A. AHMED 300 Camory place Baltimore MD 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00127

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES R JACKSON SR | | | | 2. DATE OF DEATH MONTH 7 DAY 4 YEAR 94 | | 3. TIME OF DEATH 9:15 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-32-1478 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-30-35 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | 9c. COUNTY OF DEATH BALTIMORE | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE CITY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3820 FERNHILL AVENUE | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SUPERVISOR | | 15b. KIND OF BUSINESS/INDUSTRY H.S. BAKERY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) GUY D. JACKSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA DAVIS | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) ETHEL JACKSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3820 FERNHILL AVENUE BALTIMORE, MARYLAND 21215 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUS MEM. PK., 1-8-94 BALTO., MD | | DATE 1-8-94 | | 20c. LOCATION — City or Town, State BALTO., MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin L. Williams</i> | | | | 22. NAME AND ADDRESS OF FACILITY CALVIN L. WILLIAMS FUN. SERV. 270 FREDHILTON (Gary P. March F.H., P.A.) PASS BALTO., MD | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Liver failure DUE TO (OR AS A CONSEQUENCE OF): Metastatic colon cancer Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D25205 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 6 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18 00151

10-10-8

Chas. F. Morris

(F)

ITEMS: 23 PART I, 24a, 25, 26, 27, PER DR. FILM G-712 6/18/94 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00128

| | | | | | | | |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Henry JUREWICZ | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 6:54 P M | |
| 4. SOCIAL SECURITY NUMBER 056-07-7797 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 21, 1915 | |
| 8. BIRTHPLACE (State or Foreign Country) New York | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Md. | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Essex | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 604 Seena Road | |
| 10f. ZIP CODE 21221 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Auto Mechanic | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Adolf Jurewicz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Zaradska | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Jurewicz | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Seena Road Baltimore Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. 1/8/94 Baltimore Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Fungal infection of CSF. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. PROSTATE CA WITH METS DUE TO (OR AS A CONSEQUENCE OF): c. LYMPHOMA DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death 4 weeks |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Ali Sanai</i> | | | | 29c. LICENSE NUMBER D 44793 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/93 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Ali Sanai 6730 Holabird Ave. Baltimore Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Benbow-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02100 42

OF THE COM. (1910/11)

THE COM. (1910/11)




1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00129

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--------------------------------------|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Robert L. Key ROBERT LIN KEY, SR. | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 7:35 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 460-64-3268 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-27-1924 | | 8. BIRTHPLACE (State or Foreign Country) WASHINGTON, DC | | | |
| 9a. FACILITY NAME (If not institution, give street and number) GREATER LAUREL BELTSVILLE HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH LAUREL | | | 9c. COUNTY OF DEATH PRINCE GEORGE | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE MARYLAND | | 10b. COUNTY PRINCE GEORGE | | 10c. CITY, TOWN OR LOCATION LAUREL | | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 7201 SANDY SPRING ROAD | | 10f. ZIP CODE 20707 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DRIVER | | 16b. KIND OF BUSINESS/INDUSTRY MEDICAL | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) (Unknown) JOHNSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MYRTLE (unknown) | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) SHERRY F. KEY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1293, LAUREL, MD. 20725 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CROWNSVILLE MD. VET CEM. 1/10 | | 20c. LOCATION — City or Town, State CROWNSVILLE, MD. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING RD., LAUREL, MD. 20707 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Andrew Kundera | | | | | | 29c. LICENSE NUMBER D56716 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Andrew Kundera M.D. 8317 Cherry Lane Laurel MD 20707 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | | | 32. REGISTRAR'S SIGNATURE John Benson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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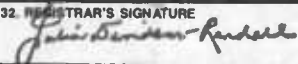
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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00130

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles John Knese | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 01 1994 | | 3. TIME OF DEATH 6:30 P M | |
| 4. SOCIAL SECURITY NUMBER 289-10-5131 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 14 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number) Hart Heritage Care Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Street | | 9c. COUNTY OF DEATH Harford | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford BALTIMORE | | 10c. CITY, TOWN OR LOCATION Street TIMONIUM | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER Orion Nursery Road 2508 LAWN SIDE ROAD | | | | 10f. ZIP CODE 21154 21093 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retail Sales/Management | | 16b. KIND OF BUSINESS/INDUSTRY Floor Covering | | | |
| 17. FATHER'S NAME (First, Middle, Last) Fred Henry Knese | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Philomena NMN Fahle | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Elaine Ann Griffin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2508 Lawnside Road, Timonium, MD 21093 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Calvary Cemetery Jan. 8, 1994 | | 20c. LOCATION — City or Town, State Ballwin, Missouri | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Martin D. Lawson | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Road, Timonium, MD 21093 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Congestive Heart Failure</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Hypertension</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Alzheimer</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>ASSISTED CARE RES.</u> | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  Alfred D. Sparks, M.D. | | 29c. LICENSE NUMBER MA 06082 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Alfred D. Sparks, M.D. 2105 Laurel Bush Road, Emmorton, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charlotte Ludlow King | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 03 1994 | | 3. TIME OF DEATH 10:00 P. M. | |
| 4. SOCIAL SECURITY NUMBER 213-48-2921 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Apr. 21 1907 | |
| 8a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center at Brightwood | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Brooklandville | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION Brooklandville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10e. STREET AND NUMBER 515 Brightfield Road | | 10f. ZIP CODE 21022 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Homemaking | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 17. FATHER'S NAME (First, Middle, Last) Stocket Whiteley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hester Hopkins | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Norval H. King, III | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Hollis Court, Timonium, MD 21093 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cemetery Jan. 6, 1993 | | 20c. LOCATION — City or Town, State Baltimore, MD | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, MD 21093 | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASP. 24. and PNEUMONIA Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. Cerebrovascular accident & LGF Hem. PLG-GIA c. ASCVD d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death 4 days 9 days |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia 2° cerebral arteriosclerosis | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D 12399 | | 29d. DATE SIGNED (Month, Day, Year) January 5, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles O'Donovan, III, M.D., 6565 N. Charles St., Suite 509, Towson, MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows injury, or other traumatic event, the medical examiner must be notified at once.

18100 J3

18100 J3




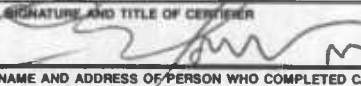
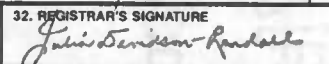
18100 J3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00132

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) NORA B. KEADY | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 1517 PM | | | | |
| 4. SOCIAL SECURITY NUMBER 579-22-2178 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2/2/1900 | | 8. BIRTHPLACE (State or Foreign Country) Ireland | | |
| 9a. FACILITY NAME (If not institution, give street and number) F.S. KEY & MERC DEPT. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO CITY | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Dundalk | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 17 Court Pleasant Apt. C3 | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Mann | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Collins | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Ann Marie Haddix | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Court Pleasant Apt. C3 Baltimore, Md. 21222 | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Heilop Service Corp. | | DATE | | 20c. LOCATION — City or Town, State Towson, Maryland | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Md. 21222 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>SEPSIS</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nonlethal | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D25203 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. MORROW MD, F.S. KEY MED CTR, EMERG DEPT. | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | |

SC100 W2

THE MICHIGAN BOTTLING

of Carbonated Beverages

PLANT

(F)

| | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Thirskield Lee (Thirskield Ann Lee)</i> | | | | 2. DATE OF DEATH MONTH <i>01</i> DAY <i>05</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>2:50</i> M | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>219-32-3638</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>59</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>10-21-34</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Joseph Richey House</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE <i>Md.</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <i>5614 Ready Ave.</i> | | | | 10f. ZIP CODE <i>21212</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Domestic</i> | | 15b. KIND OF BUSINESS/INDUSTRY <i>Self Employed</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Archie Nelson Drummond</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Daisy Gertrude Young</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Cheryll Little</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6230 Chingquapin Pkwy Balto, Md 21239</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <i>Garrison Forest Vet Hlth</i> | | 20c. LOCATION — City or Town, State <i>Dwings Mills, Md.</i> | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dr. B. Caple</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Caple Funeral Service 5502 Winner Ave. Balto, Md. 21215</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>RESPIRATORY FAILURE</i> DUE TO (OR AS A CONSEQUENCE OF): <i>AND TONGUE</i> b. <i>CANCER OF THE LARYNX WITH METASTASIS TO</i> DUE TO (OR AS A CONSEQUENCE OF): <i>LYMPH NODES AND CHEST WALL</i> c. _____ DUE TO (OR AS A CONSEQUENCE OF): _____ d. _____ | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>HOSPICE</i> | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. M. JUMMOT, M.D.</i> | | | | 29c. LICENSE NUMBER <i>D22488</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1-5-94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>L. M. JUMMOT, M.D. 220 TURNBRIDGE ROAD, BALD. MD. 21212</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 06 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julie Benson-Randall</i> | | | | | | | |

COLLONET

SA-COLLONET



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00134

| | | | | | | | |
|--|--|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>NATHANIEL LONG Sr.</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>2</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>12:51 A.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>212-30-1167</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>61</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year) <i>7 24 32</i> | 8. BIRTHPLACE (State or Foreign Country) <i>VA</i> | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>LIBERTY MEDICAL CENTER</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTO</i> | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>MD</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>BALTO</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>3421 PARK HEIGHTS AVE</i> | | | | 10f. ZIP CODE <i>21215</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12TH</i> College (1-4 or 5+) <i>LONGSHOREMAN</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>JOHN COLE</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ELIZABETH LONG</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>ELIZABETH GAINES</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3421 PARK HEIGHTS AVE BALTO, MD 21215</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <i>Garrison Forest Vet</i> | | 20c. LOCATION — City or Town, State <i>1/7/94 Owings Mills, Md</i> | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John March</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>MARCH F/H-WEST 4300 WABASH AVE</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiac arrest</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>b. <i>severe metabolic acidosis</i></p> <p>c. <i>DKA</i></p> </div> <div style="width: 45%;"> <p>d. <i>chronic alcoholism</i></p> </div> </div> | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>chronic alcoholism</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Medical Police Officer</i> | | | | 29c. LICENSE NUMBER <i>04400</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/7/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>A. IMPERIAL — LIBERTY MED. CENTER</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 0 6 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

46100 JE

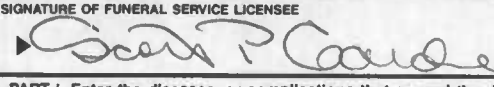

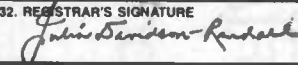
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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00135

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPHINE McKendrick LONG | | | | 2. DATE OF DEATH MONTH 01 DAY 03 YEAR 1994 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 219-10-7866 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 90 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-25-1903 | |
| 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | | 9a. FACILITY NAME (If not institution, give street and number) 1205 Hanson Road | | 9b. CITY, TOWN OR LOCATION OF DEATH Edgewood | |
| 9c. COUNTY OF DEATH Harford | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Dundalk | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 615 Aldworth Road | |
| 10f. ZIP CODE 21222 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th Grade College (14 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Baltimore City Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert McKendrick | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Long | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Margaret B. Soltysiak | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Aldworth Road Dundalk, Maryland 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) ENTOMBMENT | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 1/6/1994 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | 20d. DATE 1/6/1994 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Possible Acute Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Due to (or as a consequence of): Dementia old C.A. b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER APD 14221 | | 29d. DATE SIGNED (Month, Day, Year) 1.3.94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T.A. Brown 223 E. Blvd BALT MD 21221 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20 00132

REXCEL BOARD

11.11.11 HIGH



94 00136

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles M. Lentz | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 4, 1994 | | 3. TIME OF DEATH 8:50 P. M. | |
| 4. SOCIAL SECURITY NUMBER 212-34-4103 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 57 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 12-2-36 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH - | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY - | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 611 S. Durham Street | | | | 10f. ZIP CODE 21231 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Longshoreman | | 16b. KIND OF BUSINESS/INDUSTRY Shipping | | | |
| 17. FATHER'S NAME (First, Middle, Last) Adam P. Lentz Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Wyatt | | | |
| 19a. INFORMANT'S NAME (Type/Print) Calvin Wyatt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8007 Grayhaven Rd. Balto. Co. Md. 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery Jan. 8, 94 | | 20c. LOCATION — City or Town, State Balto. Co. Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George A. Weber & Sons Inc. | | | | 22. NAME AND ADDRESS OF FACILITY George A. Weber & Sons Inc. 705 S. Ann St. Balto. Md. 21231 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>Adenocarcinoma of Lung</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death 4 months |
| | | b. <u>Diffuse Metastasis</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | 4 months |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | 3 weeks |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>COPD CAD</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ed Walker DO Rehabilitation Resident Good Samaritan Hospital | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ED WALKER DO Good Samaritan Hospital Baltimore MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1-4 JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Sanderson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00137

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BENJAMIN F. MARION | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 02 94 | | 3. TIME OF DEATH 4:20 P^M | |
| 4. SOCIAL SECURITY NUMBER 212-42-6443 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 48 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1 23 45 | |
| 9a. FACILITY NAME (If not institution, give street and number) 514 SHIRLEY MANOR ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MD | | | | 10b. COUNTY BALTO | | 10c. CITY, TOWN OR LOCATION BALTO | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 514 SHIRLEY AVE | | | |
| 10f. ZIP CODE 21136 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNKNOWN | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) EDWARD MARION | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GUSSIE TENDER | | | |
| 19a. INFORMANT'S NAME (Type/Print) CHERYL J. MARION | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SHASTA CIRCLE APT L OWINGS MILLS, MD 21117 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) KING MEMORIAL PARK | | 20c. DATE 1/8/94 | | 20d. LOCATION — City or Town, State RANDALLSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Stab Wounds (2) of Chest and Left Arm | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) unknown | | 28b. TIME OF INJURY unknown | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED Subject cut and stabbed | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 514 SHIRLEY MANOR RD. | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/03/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CASE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows a traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) VIRGINIA MORANT | | | | 2. DATE OF DEATH MONTH 1 DAY 05 YEAR 94 | | 3. TIME OF DEATH 12 30 A M | |
| 4. SOCIAL SECURITY NUMBER 216-18-7458 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-12-1920 | |
| 8. BIRTHPLACE (State or Foreign Country) SALISBURY, MARYLAND | | 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2725 WALBROOK AVENUE | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DAYCARE WORKER | | 16b. KIND OF BUSINESS/INDUSTRY BALTIMORE CITY | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM SAMPLE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GERTRUDE SAMPLE | | | |
| 19a. INFORMANT'S NAME (Type/Print) DOROTHY HAMMOND | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2524 HOLLINS FERRY ROAD, BALTIMORE, MD. 21230 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of MOUNT ZION CEMETERY CEDAR HILL CEMETERY | | DATE | | 20c. LOCATION Baltimore Maryland GLEN BURNIE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles D. Brown | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): leg wound DUE TO (OR AS A CONSEQUENCE OF): peripheral vascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death 3 days 30 day years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiac arrest | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. S. Murphy MD | | | | 29c. LICENSE NUMBER 44417643SMHAB | | 29d. DATE SIGNED (Month, Day, Year) 1-5-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARGARET S. MURPHY UNIV. OF MD BALTIMORE | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 0 6 1994 | | 32. REGISTRAR'S SIGNATURE John S. ... | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

12th 2nd 4th



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00139

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---------------------------------|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CATHERINE PEARL MAGGITT | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 03 94 | | 3. TIME OF DEATH 4:30 P M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 218-82-6989 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 21 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Mar. 12 1972 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2364 NORTH CLIFF ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH JARRETTSVILLE | | | | 9c. COUNTY OF DEATH HARFORD | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Jarrettsville | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 2364 Northcliff Drive | | | | 10f. ZIP CODE 21084 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 1 | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student | | 17. KIND OF BUSINESS/INDUSTRY Harford Community College | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ronald Francis Maggitti | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Pearl Allen | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ronald Francis Maggitti | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2701 Christopher Ave., Baltimore, MD 21214 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns. Jan 8, 1994 | | 20c. LOCATION — City or Town, State Timonium, MD 21093 | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Road, Timonium, MD 21093 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Drowning</u> DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Schizophrenia</u> <u>Depression</u> | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 01/03/94 | | 28b. TIME OF INJURY unknown | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT DROWNED | | | | | |
| 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) HOME | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2364 NORTH CLIFF ROAD | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dennis Chute | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/04/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn street, / Baltimore, Maryland 21201 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE Julie Sanders-Randall | | | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The funeral director must retain this certificate for 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR HEALTH CARE PROVIDER: The law requires that the death certificate be executed within 48 hours after death. Page 5 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 94 00140 | |
|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN R. MOBLEY | | 2. DATE OF DEATH MONTH 1 DAY 1 YEAR 94 | | 3. TIME OF DEATH 11:35 P | |
| 4. SOCIAL SECURITY NUMBER 219- 40- 9264 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 50 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 4-2-43 | | 8. BIRTHPLACE (State or Foreign Country) S. CAROLI NA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) NORTHWEST HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH n/a | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MARYLAND | | 10b. COUNTY N?A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 3415 BARRY PAUL ROAD apt. T- 2 | | 10f. ZIP CODE 21207 | |
| 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES ARMY | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 TH | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED | | 16b. KIND OF BUSINESS/INDUSTRY DEPT. of SANITATION | |
| 17. FATHER'S NAME (First, Middle, Last) MANUEL MOBLEY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIE BROWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) ROSALIE MOBLEY | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3415 BARRY PAUL ROAD, BALTIMORE, MARYLAND 21207 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHILL MEMORIAL GARDEN | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lee V. Holland | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → BILATERAL PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | Approximate interval between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL FAILURE WITH METABOLIC ENCEPHALOPATHY; DIABETES MELLITUS; HYPERTENSION | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 1-1-94 | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER RANDOLPH B. CONANAN M.D. | | 29c. LICENSE NUMBER P 19502 | |
| 29d. DATE SIGNED (Month, Day, Year) 1-1-94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ORLANDO B. CONANAN M.D. NORTHWEST HOSP. CENTER RANDOLPHSTOWN Md. 21133 | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | 32. REGISTRAR'S SIGNATURE John B. ... | | | |

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

1

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 94 00141 | |
|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ARNOLD FRITZ MONSRUD | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 05, 1994 | |
| 3. TIME OF DEATH 05:50 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 050-07-2450 | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 76 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 1/16/17 | 8. BIRTHPLACE (State or Foreign Country) New York | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH N/A |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE North Carolina | 10b. COUNTY Moore | 10c. CITY, TOWN OR LOCATION Pinehurst | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 330 Sugar Pine Drive | | 10f. ZIP CODE 28374 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Management | | 16b. KIND OF BUSINESS/INDUSTRY Airline | |
| 17. FATHER'S NAME (First, Middle, Last) Fritz Monsrud | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gunhild Olstad | | |
| 19a. INFORMANT'S NAME (Type/Print) L.M. Lev | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8324 Tally Ho Road Lutherville, Maryland 21093 | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pine Lawn Cemetery | | 20c. LOCATION — City or Town, State 1/8 Southern Pines, N.C. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis Stephen Xenakis</i> Dennis Stephen Xenakis | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Prostate Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | Approximate Interval Between Onset and Death 2 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Hopkins</i> MD | | | | 29c. LICENSE NUMBER L9706 | |
| | | | | 29d. DATE SIGNED (Month, Day, Year) 1/15/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Hospital, Baltimore MD | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | 32. REGISTRAR'S SIGNATURE <i>John Benson-Randall</i> | | | |


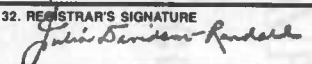
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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00142

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) KIRK MOSLEY MD | | | | 2. DATE OF DEATH MONTH JANUARY DAY 3 YEAR 1994 | | 3. TIME OF DEATH 6:45 P M | |
| 4. SOCIAL SECURITY NUMBER 447-32-6542 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 5 1906 | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Timonium | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2118 Woodfork Rd. | | | | 10f. ZIP CODE 21093 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Physician | | 16b. KIND OF BUSINESS/INDUSTRY Medical | | | |
| 17. FATHER'S NAME (First, Middle, Last) Wiley Thornton Mosley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maude Greenlee | | | |
| 19a. INFORMANT'S NAME (Type/Print) W. Henry Mosley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2118 Woodfork Rd., Timonium, MD 21093 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Memorial Park Cem. 1/8/94 | | 20c. LOCATION — City or Town, State Enid, Oklahoma | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Lowell M. Lemmon | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, MD 21093 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary edema DUE TO (OR AS A CONSEQUENCE OF): b. metastatic Prostate Cancer DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death 10 hrs. 10 yrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David E. Weng M.D. | | | | 29c. LICENSE NUMBER JHH L0680 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID E. WENG 600 N. Wolfe St. Johns Hopkins Hopkins Baltimore MD 21205 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be retained by the hospital or attending physician. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24107 28

REVENUE DEPT

EX-110M-1111

1

94-0019-023

l.r.b.

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-708 2/18/94 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00143

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) DAVID McKeegan MORRIS | | | | 2. DATE OF DEATH 01 MONTH 01 DAY 1994 YEAR | | 3. TIME OF DEATH 9:40P M | |
| 4. SOCIAL SECURITY NUMBER 219-17-8640 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 14 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 6, 1979 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) GARRETT COUNTY MEMORIAL E.R. | | 9b. CITY, TOWN OR LOCATION OF DEATH OAKLAND | |
| 9c. COUNTY OF DEATH Garrett | | | | 10a. STATE Maryland | | 10b. COUNTY Balto. | |
| 10c. CITY, TOWN OR LOCATION Cockeysville | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 19 Dellwood Ct. | |
| 10f. ZIP CODE 21030 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student | | 16b. KIND OF BUSINESS/INDUSTRY School | |
| 17. FATHER'S NAME (First, Middle, Last) Stephen Alan Morris | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Deborah McKeegan | | | |
| 19a. INFORMANT'S NAME (Type/Print) Stephen Alan Morris | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10e | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns 1/5/94 | | 20c. LOCATION — City or Town, State Timonium, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald E. Schaper</i> | | | | 22. NAME AND ADDRESS OF FACILITY 1050 York Rd. 21204 Ruck Towson Funeral Home, Inc. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIA DUE TO BLUNT FORCE IMPACT TO CHEST DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 1-1-94 | | 28b. TIME OF INJURY 7:35 PM | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED SUBJECT FELL WHILE SKIING | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) WISP SKI SLOPE | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) MCHENRY, MARYLAND | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wayne D. McKel</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/02/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYANN D. KOREN 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John T. Davis</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00144

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Nicholas J. Naglieri</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> - DAY <i>3</i> - YEAR <i>1994</i> | | 3. TIME OF DEATH <i>10:34P. M.</i> | | | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>220-18-5808</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>65</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>2-2-1928</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key M.C.</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | | | 9c. COUNTY OF DEATH <i></i> | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i></i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER <i>3405 Leverton Avenue</i> | | | | 10f. ZIP CODE <i>21224</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>2+</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Employee</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Bethlehem Steel</i> | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Louis Naglieri</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Angelina Spadacini</i> | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Doris L. Naglieri</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3405 Leverton Ave Balto Md 21224</i> | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>OAKLAWN cem</i> | | DATE <i></i> | | 20c. LOCATION — City or Town, State <i>Balto. Maryland</i> | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles J. Zannino</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Joseph N. Zannino Jr. Funeral Home 263 S. Conkling St. Balto. Md. 21224</i> | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac arrhythmia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Renal cell cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i></i> | | | | | | | | Approximate Interval Between Onset and Death <i>Minutes</i> <i>Years</i> <i>?</i> | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i></i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] MD</i> | | | | | | | | 29c. LICENSE NUMBER <i>15408</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/4/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>D. MacDonald 9 S. Highland Ave 21224</i> | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 06 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | | | | | |

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22 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00145 | |
|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) HALLIE D. OLLIE | | | | 2. DATE OF DEATH MONTH 01 DAY 05 YEAR 94 | | 3. TIME OF DEATH 4:41 AM | |
| 4. SOCIAL SECURITY NUMBER 216-34-5220 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-2-14 | |
| 8. BIRTHPLACE (State or Foreign Country) Va | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Saint Agnes Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Balto | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 820 S. Caton Ave | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Richard Johnson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie McDaniel | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gladys Collins | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4201 Marie Ave Balto, MD 21207 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Mem Park 4/5/94 | | 20c. LOCATION — City or Town, State Arbutus MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladys Wanes | | | | 22. NAME AND ADDRESS OF FACILITY March F. H. West 4300 Wabash Ave | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASPIRATION PNEUMONIA Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): LEFT FRONTAL HEMORRHAGE c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION FEVER | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Gladys Collins MEDICAL RESIDENT | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 01-05-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gabriel A. Guzman MD 901 Caton Ave BALTI, MD 21229 St Agnes Hosp. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 0 6 1994 | | | | 32. REGISTRAR'S SIGNATURE John Benison-Randall | | | |

RECEIVED

Handwritten notes and signatures in the upper section of the document.

Main body of handwritten text, appearing to be a detailed report or account.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00146

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>O'Hagan, Mary Regina</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>01 02 94</i> | | | | 3. TIME OF DEATH <i>7:15a</i> | | | |
| 4. SOCIAL SECURITY NUMBER <i>217-64-2711</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) <i>86</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Sept. 1, 1907</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Dulaney Towson Nursing Home</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Towson</i> | | | | 9c. COUNTY OF DEATH <i>BALTIMORE</i> | | | |
| 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY <i>BALTIMORE</i> | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <i>3004 Woodside Avenue</i> | | | | 10f. ZIP CODE <i>21234</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (14 or 16+) <i>College</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Homemaker</i> | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Edward Francis Mulgrew</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Jane Murphy</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>John P. O'Hagan</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>825 Ramshead Circle Cockeysville, MD 21030</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>New Cathedral Cemetery Jan. 5</i> | | 20c. LOCATION — City or Town, State <i>Baltimore</i> | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Martin D. Lawson</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Cockeysville, MD 21030</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Right upper lobe atelectasis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Bronchogenic carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Right cerebral infarction</i> <i>Acute inflammation</i> <i>Longstanding Diabetes</i> | | | | | | | | Approximate Interval Between Onset and Death <i>1 hour</i> <i>2 weeks</i> <i>6 months</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Right cerebral infarction</i> <i>Acute inflammation</i> <i>Longstanding Diabetes</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) <i>N/A</i> | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martin D. Lawson</i> | | | | 29c. LICENSE NUMBER <i>D-14957</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1-2-94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>STEPHEN R. SMITH, MD, 8709 HARFORD RD., BALTIMORE, MD 21234</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 06 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John B. ...</i> | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00147 | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) E. WALLACE OEST | | | | 2. DATE OF DEATH MONTH 01 DAY 03 YEAR 94 | | | | 3. TIME OF DEATH 2:25 A.M. | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 705-05-2760 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 04/13/05 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) EDEN WOLD RETIREMENT HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | | | 9c. COUNTY OF DEATH BALTIMORE | | | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 10a. STREET AND NUMBER 800 Southerly Road Apt. 502 | | | | 10f. ZIP CODE 21286 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | |
| 11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs. College (1-4 or 5+) 2 yrs. | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Travel Agent | | | | 16b. KIND OF BUSINESS/INDUSTRY B & O Railroad | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Oest | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Amelia Unknown | | | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Dorothy S. Oest | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10 | | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Borraine Park Cemetery 1/6/94 | | DATE 1/6/94 | | 20c. LOCATION — City or Town, State Woodlawn, Maryland | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul L. [Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACID-CNF b. CVA late effects c. Dementia multi infarct type d. | | | | | | | | | | | | Approximate interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald W. Minizer MD</i> | | 29c. LICENSE NUMBER D07296 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD W. MINIZER MD, 3009 EVERGREEN AVE BALTIMORE | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John [Signature]</i> | | | | | | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00148

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) HAZEL M. OLIVER | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 05 94 | | 3. TIME OF DEATH 5:49 A. M. | |
| 4. SOCIAL SECURITY NUMBER 214-30-2567 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 15, 1905 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not Institution, give street and number) 1425 OLD STEPNEY ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH ABERDEEN | |
| 9c. COUNTY OF DEATH HARFORD COUNTY | | | | 10a. STATE Maryland | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION Baltimore City | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 5906 Greenhill Avenue | |
| 10f. ZIP CODE 21206 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) _____ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker | | 16b. KIND OF BUSINESS/INDUSTRY Home | |
| 17. FATHER'S NAME (First, Middle, Last) William A. Wiseman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Wiseman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joan H. Pfister | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5906 Greenhill Avenue, Baltimore, Maryland 21206 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 1/8/94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen M. Murphy</i> | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John E. Smialek</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 1-5-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN E. SMIALEK MD. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John E. Smialek</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00149

| | | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CATHERINE WILLIAMS PAULHAMUS | | | | 2. DATE OF DEATH MONTH JANUARY DAY 05, 1994 YEAR | | 3. TIME OF DEATH 03:10 M | | | | |
| 4. SOCIAL SECURITY NUMBER 219-68-8832 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs., last birthday) 37 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2/29/56 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | 9c. COUNTY OF DEATH Baltimore | | | |
| 10a. STATE Md. | | | 10b. COUNTY Frederick | | 10c. CITY, TOWN OR LOCATION New Market | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 6714 Meadowlawn Circle | | | | 10f. ZIP CODE 21774 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Social Worker | | | 16b. KIND OF BUSINESS/INDUSTRY State of Md. | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Barrington Paulhamus | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Davis | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) E. Thaddeus Paulhamus | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3808 Greenmount Ave. Balto. Md. 21218 | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 1/6 | | DATE | | 20c. LOCATION — City or Town, State Baltimore, MD | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., Inc. 299 Frederick Road Baltimore, MD 21228 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): a. Pneumonia (Pneumonia PCP) b. Disseminated H IV, AIDS c. d. | | | | | | | Approximate Interval Between Onset and Death 2 wks 5 YRS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Disseminated Gonorrhea Insulin dependent diabetes CACHExia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Philip E. H. R. M.D. | | | | 29c. LICENSE NUMBER D.36709 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Philip E. H. R. M.D. 5550 Newbury St BALT, MD | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | | |

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21210 Ave. Balto. Md. 21210

94 00150

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James Henry Rosier | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 5, 1994 | | | | 3. TIME OF DEATH 12 Noon M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-36-8499 | | | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 56 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 17, 1937 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 219 Warren Road | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cockeysville | | | | 9c. COUNTY OF DEATH BALTIMORE | | | | | |
| 10a. STATE MARYLAND | | | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION COCKEYSVILLE | | | | | | | |
| 10e. STREET AND NUMBER 219 Warren Road | | | | | | 10f. ZIP CODE 21030 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Ret. Engineer/Supervisor | | | | | | | |
| 16b. KIND OF BUSINESS/INDUSTRY Amtrack | | | | 17. FATHER'S NAME (First, Middle, Last) Charles Rober Rosier | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mae Francis Naylor | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Grace Yarema Rosier | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 219 Warren Road, Cockeysville, MD. 21030 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. Line Cemetery | | | | DATE JAN 8 | | 20c. LOCATION — City or Town, State Md. Line, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE PROVIDER Martin D. Lawson | | | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, MD 21093 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pancreatic Carcinoma</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate Interval Between Onset and Death 1 year | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. John Downs, MD | | | | | | 29c. LICENSE NUMBER D33624 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. John Downs, 7705 Osler Drive, Suite 504, Towson, MD 21204 | | | | | | | | | | | | | | | |
| 31. DATE FILED JAN 6 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00151

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BEVERLY ROYSTER | | | | 2. DATE OF DEATH MONTH 01 DAY 01 YEAR 94 | | 3. TIME OF DEATH 2:32 P M | |
| 4. SOCIAL SECURITY NUMBER 219-50-1369 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 45 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/28/48 | |
| 9a. FACILITY NAME (If not institution, give street and number) 102 DIENER PLACE APT. #201 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH BALTO., MD | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 104 DIENER PLACE APT. 201 | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES HART | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY | | | |
| 19a. INFORMANT'S NAME (Type/Print) REV. HAROLD HART | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1303 IDLEWOOD ROAD BALTIMORE, MD 21208 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem. | | 20c. LOCATION — City or Town, State Owings Mills, MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207 | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gunshot wound of chest DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) PARKING LOT | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 01/01/1994 | | 28b. TIME OF INJURY 2:20 PM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED SUBJECT SHOT | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) PARKING LOT | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 102 DIENER PLACE | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) 01/02/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00152

| | | | | | | | | |
|---|--|---|---|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William Harvey Schoenhaar | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 3 94 | | 3. TIME OF DEATH 1:05 P M | | |
| 4. SOCIAL SECURITY NUMBER 219-01-5852 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 1, 1920 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | | |
| RESIDENCE OF DECEDENT | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION TOWSON | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 947 Ellendale Drive | | | | 10f. ZIP CODE 21286 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Labor Relations Director | | 16b. KIND OF BUSINESS/INDUSTRY State of Maryland | | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Frederick Schoenhaar | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian V. Harwood | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sarah S. Day Kunzelman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 Ellendale Drive, Towson, MD 21286 | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery JAN. 6 | | 20c. LOCATION — City or Town, State Pikesville | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSER Martin D. Lawson | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, MD 21093 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PROSTATE CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death 2 yrs. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R. Faulkner M.D. | | | | 29c. LICENSE NUMBER D25643 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kendall R. Faulkner, M.D., 2300 Dulany Valley Road, Towson, Maryland 21204 | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

64 00123

OFFICE RECORD

1964

15

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 001531

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) William Edward Schoeberlein <i>SCHOEBERLEIN WILLIAM E</i> | | | | 2. DATE OF DEATH MONTH 1 DAY 5 YEAR 94 | | 3. TIME OF DEATH 3:40 PM | |
| 4. SOCIAL SECURITY NUMBER 213-14-0127 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month/Day/Year) 10/1/19 | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH MARYLAND | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Catonsville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 715 Maiden Choice Lane, HV 314 | | | | 10f. ZIP CODE 21228 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II & Korea | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CPA / Attorney | | 16b. KIND OF BUSINESS/INDUSTRY Accounting / Legal | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Schoeberlein | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Wojnechoska | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Louise Schoeberlein | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Maiden Choice Ln., HV 314 Baltimore, MD 21228 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. John's Catholic Ch. Cemetery 1/8 | | 20c. LOCATION — City or Town, State Long Green, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George E. MacNabb</i> George E. MacNabb | | | | 22. NAME AND ADDRESS OF FACILITY MacNabb Funeral Home, P.A. 301 Frederick Road Balto., MD 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Lymphoma - large cell type a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CCF, AF, HTN, | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard N. Nantz MD</i> RESIDENT | | | | 29c. LICENSE NUMBER AS2438528 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. SATYANARAYANA, ST. AGNES HOSPITAL, BALTIMORE - 21229 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-0029-033

M.L.JR.

ITEMS: 23 PART I, 27, PER MEO FILM G-707 1/27/94 t.t

94 00154

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RICHARD ROY SELBY, IV | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 02 94 | | 3. TIME OF DEATH 1:29 PM | |
| 4. SOCIAL SECURITY NUMBER 089-46-9420 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 41 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/26/52 | |
| 8. BIRTHPLACE (State or Foreign Country) Ohio | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 4813 QUEENSBURY ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH RIVERDALE | | 9c. COUNTY OF DEATH PRINCE GEORGES | |
| 10a. STATE Md. | | 10b. COUNTY Prince Georges | | 10c. CITY, TOWN OR LOCATION Riverdale | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4813 Queensbury Road | | | | 10f. ZIP CODE 20737 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES N/A | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 years | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Librarian | | 15b. KIND OF BUSINESS/INDUSTRY P.G. Co. Public Library | | | |
| 17. FATHER'S NAME (First, Middle, Last) Richard Roy Selby III | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Roberta Alice Hess | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Richard R. Selby III | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 731 Clubhouse Dr. Aptos, Ca. 95003 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 1/5 | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. KYPHOSCOLIOSIS AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH FOCAL PNEUMONIA IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King M.D. | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/03/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

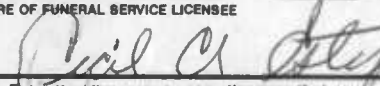
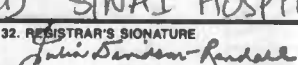
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00155

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FRANKLIN SMITH Smith | | | | 2. DATE OF DEATH MONTH 01 DAY 01 YEAR 94 | | 3. TIME OF DEATH 1025A | |
| 4. SOCIAL SECURITY NUMBER 213 26 8774 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 62 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 5/11/31 | 8. BIRTHPLACE (State or Foreign Country) MD. | | |
| 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 813 Winston Ave. | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 5/49 10/52 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Afr. American | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Garland Harcum | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura S. Tilghman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorethea Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Winston Ave. Balto. MD. 21212 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest 1/7/94 | | 20c. LOCATION — City or Town, State Owings Mills, MD. | | DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Progressive renal failure DUE TO (OR AS A CONSEQUENCE OF): b. HTN DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Madhu Jain MD | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MADHU JAIN MD SINAI HOSPITAL BALTIMORE MD. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

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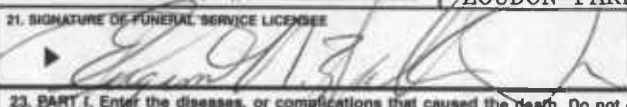

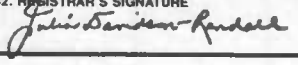
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After examination has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, confirm 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00156

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John D. Smith | | | | 2. DATE OF DEATH MONTH 01 DAY 02 YEAR 94 | | 3. TIME OF DEATH 7 40 PM | |
| 4. SOCIAL SECURITY NUMBER 238-07-5992 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2/22/10 | |
| 9a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3023 WESTWOOD AVE | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: AFR. AMERICAN | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES SMITH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CORA W. SMITH | | | |
| 19a. INFORMANT'S NAME (Type/Print) EVELYN PARKER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 357 BACK RIVER NECK RD ESSEX MD 21221 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK 1/7/94 | | DATE | | 20c. LOCATION — City or Town, State BALTIMORE MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory/Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Pancreatic Cancer b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate interval Between Onset and Death 1 month | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  M.D. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/2/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 22 S. Greene St. University Hospital Dept. Medicine | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1 JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

22100 40

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Office, Division of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00157 | |
|---|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Clinton Dewitt Savage | | | | 2. DATE OF DEATH MONTH 1 DAY 1 YEAR 94 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 215 10 4866 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1/16/12 | |
| 8. BIRTHPLACE (State or Foreign Country) MD | | | | 9. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | |
| 10. COUNTY OF DEATH MD | | | | 11. STREET AND NUMBER 7 N. Bentlouw St. | | | |
| 12. ZIP CODE 21223 | | | | 13. CITIZEN OF WHAT COUNTRY? USA | | | |
| 14. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 15. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | |
| 16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 17. RACE — American Indian, Black, White, etc. Specify: Afr. American | | | |
| 18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 19. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired | | | |
| 20. KIND OF BUSINESS/INDUSTRY A.D. Anderson | | | | 21. FATHER'S NAME (First, Middle, Last) Jessie Savage | | | |
| 22. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Johnson | | | | 23. INFORMANT'S NAME (Type/Print) Alice Peacock | | | |
| 24. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5515 Gist Ave. Balto, Md. 21215 | | | | 25. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | |
| 26. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill 1/6/94 | | | | 27. DATE 1/6/94 | | | |
| 28. LOCATION — City or Town, State Brooklyn Md. | | | | 29. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | |
| 30. NAME AND ADDRESS OF FACILITY Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto, Md. 21217 | | | | 31. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Prostate Carcinoma</i> b. <i>Diabetes Mellitus</i> c. <i>Abnormal Fibrillation</i> d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| 32. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 33. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 34. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 35. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 36. HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | | | 37. OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 38. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 39. 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 40. 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 41. 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 42. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 43. 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 44. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 45. 29c. LICENSE NUMBER 13132 | | | |
| 46. 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | | 47. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 24304 Mountain Road Pasadena Md 21222 | | | |
| 48. 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 49. 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00158

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ruby S Strider | | | | 2. DATE OF DEATH MONTH DAY YEAR January 4, 1994 | | 3. TIME OF DEATH 6:18 A. M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-09-9354 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 20, 1918 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH Baltimore County | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore County | | 10c. CITY, TOWN OR LOCATION Baltimore | | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 24 Torque Way | | 10f. ZIP CODE 21220 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 9th Grade | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Lloyd S. Warfield | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Irene Barth | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) George M. Strider | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 835 Western Chapel Road, Westminster, Maryland 21157 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery 1/6/94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen M. Murphy | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Renal Failure DUE TO (OR AS A CONSEQUENCE OF): c. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): d. Diabetes Mellitus Approximate Interval Between Onset and Death 2 weeks | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastrointestinal Bleeding Chronic Obstructive Pulmonary Disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John J. Loh | | | | 29c. LICENSE NUMBER H35593 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. John J. Loh 617 A Stemmers Run Road Balto., Md. 21221 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE John J. Loh | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 94 00159 | |
|---|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) | | Flossie Scipio | | 2. DATE OF DEATH | |
| Flossie Elizabeth Scipio | | January 4, 1994 | | 3. TIME OF DEATH | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | |
| 213-26-1354 | | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 66 YRS. | |
| 9a. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH | |
| 1330 Buckhorn Road | | Sykesville | | Carroll County | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | |
| Maryland | | Carroll County | | Sykesville | |
| 10d. INSIDE CITY LIMITS? | | 10e. STREET AND NUMBER | | 10f. ZIP CODE | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1330 Buckhorn Road | | 21784 | |
| 11. MARITAL STATUS | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 13. WAS DECEASED OF HISPANIC ORIGIN? | |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | IF YES, GIVE WAR OR DATES | | Specify: | |
| 15. DECEASED'S EDUCATION | | 16a. DECEASED'S USUAL OCCUPATION | | 16b. KIND OF BUSINESS/INDUSTRY | |
| (Specify only highest grade completed) | | (Give kind of work done during most of working life. Do NOT use retired.) | | | |
| Elementary/Secondary (0-12) | | College (1-4 or 5+) | | Nurses Aide | |
| 12 | | | | Health Care | |
| 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| Herbert Morris | | Flossie Purnell | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| Mr. Robert Scipio | | 1330 Buckhorn Road Sykesville, MD 21784 | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | | Springfield Cemetery January 8, 1994 Sykesville, MD | | | |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY | | | |
| Burr L. Haight | | HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410) 795-1400 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Pneumosepsis | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Leukemia | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. WAS AN AUTOPSY PERFORMED? | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| Atherosclerotic Cardiovascular Disease | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH (Check only one) | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined | | | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | J. M. Heather, MD | | D33320 | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29d. DATE SIGNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | 1/4/94 | |
| F. M. Gloth, Jr., MD 95 Carroll Street Westminster, MD 21157 | | | | | |
| 31. DATE FILED (Month, Day, Year) | | 32. REGISTRAR'S SIGNATURE | | | |
| JAN 06 1994 | | Jolie Davidson-Randall | | | |

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REVAUGH BOARD OF DIRECTORS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked for item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 94 00160

| | | | | | | | | | | | |
|---|--|--|---|---|--|--|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BLANCHE W. TURNER | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 - 02 - 94 | | 3. TIME OF DEATH 10:30 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 249-78-1596 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 49 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03 08 45 | | 8. BIRTHPLACE (State or Foreign Country) S. Carolina | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Med. Ctr. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH Baltimore | | | |
| 10a. STATE MD. | | | 10b. COUNTY Anne Arundel | | | 10c. CITY, TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 103 Zepplin Avenue | | | | 10f. ZIP CODE 21225 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4 | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles A. Williams | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Richard Turner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Zepplin Avenue Anne Arundel, MD 21225 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Flat Rock Bapt. CH. Cem. | | DATE | | 20c. LOCATION — City or Town, State Greenville, S.C. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dorothy Hester CFSP #281 | | | | 22. NAME AND ADDRESS OF FACILITY E.L. Phillips F/H 1721-27 N. Monroe ST. Balto., MD. 21217 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Non Hodgkin's lymphoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Spontaneous</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul M. [Signature]</i> MD | | | | 29c. LICENSE NUMBER D30829 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Paul M. [Signature]</i> GPM [Signature] Center Baltimore 21204 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John [Signature]</i> | | | | | | | |

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EXHIBIT 101

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EXHIBIT 101

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 94 00161 | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|----------|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | REG. NO. | |
| 1. DECEDENT'S NAME (First, Middle, Last) ROSCOE WERTS | | | | | | 2. DATE OF DEATH MONTH 1 DAY 2 YEAR 1994 | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-12-5796 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 74 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 | 7. DATE OF BIRTH (Month, Day, Year) 3-19-1919 | | 8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 5949 THE ALAMEDA | | | | 10f. ZIP CODE 21239 | | 10g. CITIZEN OF WHAT COUNTRY? USA. | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 8+) <input type="checkbox"/> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) WALTER BOUKNIGHT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5949 THE ALAMEDA, BALTIMORE, MARYLAND 21239 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | OATE | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST pneumonia a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic Bedridden State | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Fredric S. Sirkis M.D. | | | | 29c. LICENSE NUMBER D22645 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREDRIC S. SIRKIS M.D. 7151 HOLABIRD AVE, BALTO. MD. 21222 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be signed by the attending physician and completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed within 24 hours after death, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00162 | |
|--|--|--|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Willard Gordon Webster | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 4, 1994 | | | | 3. TIME OF DEATH 2:30 P M | |
| 4. SOCIAL SECURITY NUMBER 220-14-6622 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 31, 1913 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) 13802 Devonfield Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baldwin | | | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALDWIN | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 13802 Devonfield Drive | | | | 10f. ZIP CODE 21013 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Internal Auditor | | | | 16b. KIND OF BUSINESS/INDUSTRY Accounting | | | |
| 17. FATHER'S NAME (First, Middle, Last) Andrew Shirley Webster | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elvah May Moore | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Bruce Howard Webster, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701 Uxbridge Road, Balto., Md 21234 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. John's Luth. Church Cem | | DATE 8 | | 20c. LOCATION — City or Town, State Sweet Air, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, MD 21093 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. COPD DUE TO (OR AS A CONSEQUENCE OF): c. Chronic Atrial Fibrillation DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 1/4/94 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Frank Sanzaro | | | | 29c. LICENSE NUMBER D22607 | |
| 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Frank Sanzaro, 3313 Paper Mill Rd., Phoenix, MD 21131 | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE John D. Anderson | | | | | |

34 00185

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "whereas" and "and" are visible.]

APPROVED: _____
SPECIAL AGENT IN CHARGE



94 00163

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Barbara A. Wilson</u> | | | | 2. DATE OF DEATH MONTH <u>1</u> DAY <u>5</u> YEAR <u>94</u> | | 3. TIME OF DEATH <u>2:44 A</u> M | |
| 4. SOCIAL SECURITY NUMBER <u>217-68-0221</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) <u>38</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>12-11-55</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>UNIVERSITY HOSPITAL</u> | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u> | | 9c. COUNTY OF DEATH <u>N/A</u> | | | |
| 10a. STATE <u>MD</u> | | 10b. COUNTY <u>N/A</u> | | 10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>4131 EIERMAN AVENUE</u> | | | | 10f. ZIP CODE <u>21206</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>12th</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>UNEMPLOYED</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>N/A</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>LEROY HARRISON</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>FANNIE EPPS</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>GAYLORD WILSON</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4131 EIERMAN AVE./BALTIMORE, MD 21206</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>KING MEMORIAL PARK</u> | | 20c. LOCATION — City or Town, State <u>RANDALLSTOWN, MD</u> | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY <u>WM.C.MARCH F.H./1101 E. NORTH AVENUE</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Intracranial Hemorrhage</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death <u>12 hrs.</u> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Cocaine use, hypertension</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <u>1/5/94</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Kevin Zinner MD University of Maryland Hospital</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 06 1994</u> | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the funeral home has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 00164

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) HERMAN AUSTIN | | | | 2. DATE OF DEATH MONTH 1 DAY 3 YEAR 94 | | 3. TIME OF DEATH 2:00 PM | |
| 4. SOCIAL SECURITY NUMBER 219 01 6074 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/20/14 | |
| 8a. FACILITY NAME (If not institution, give street and number) 3406 FAIRVIEW RD. | | | | 8b. CITY, TOWN OR LOCATION OF DEATH BALTO, Md. | | 8c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY BALTO | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3406 FAIRVIEW RD. | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES JUL 5/45 - FEB 4/47 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Elementary College (1-4 or 5+) Welder | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Welder | | 16b. KIND OF BUSINESS/INDUSTRY Beth-Steel | | | |
| 17. FATHER'S NAME (First, Middle, Last) SAMUEL AUSTIN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) THEKESA SAYAGO | | | |
| 19a. INFORMANT'S NAME (Type/Print) ELLA AUSTIN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 FAIRVIEW Rd BALTO, Md 21207 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CROWNSVILLE Vet. Cem 1/7 | | 20c. LOCATION — City or Town, State CROWNSVILLE, Md | | 20d. DATE 1/7 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Timothy Rendon | | | | 22. NAME AND ADDRESS OF FACILITY LOCKS FUNERAL HOME 1304 N. CENTRAL AVE | | | |
| 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE CEREBROVASCULAR DISEASE CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 28g. DATE SIGNED (Month, Day, Year) 1/6/94 | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER John D. Rendon | | 29c. LICENSE NUMBER D40059 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) UNIVERSITY OF MARYLAND HOSPITAL DEPT OF MEDICINE 22 S. GREENE ST BALTIMORE MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE John D. Rendon | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00165

| | | | | | | | |
|--|--|--|---|--|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VIOLET M. ASKINS | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 10:25 AM | |
| 4. SOCIAL SECURITY NUMBER 215-74-7780 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 85 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) MAY 1, 1908 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) FREDERICK HOUSE (CHARLESTOWN) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION CATONSVILLE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 709 MAIDEN CHOICE LANE-#FH416 | | | | 10f. ZIP CODE 21228 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: XX | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY HOMEMAKING | | | |
| 17. FATHER'S NAME (First, Middle, Last) HERBERT LIONEL TILGHMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JESSICA WILT | | | |
| 19a. INFORMANT'S NAME (Type/Print) PATRICIA A. RUGGLES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4332 MILLERS STATION ROAD - MILLERS, MD. 21107 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LAKEVIEW MEMORIAL PARK 1/7 | | 20c. LOCATION — City or Town, State SYKESVILLE | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. Maf Coleman</i> | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Failure</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Pneumonia</i> <i>Emphysema</i> <i>Arteriosclerosis</i> | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Heart Disease</i> <i>Coronary Artery Disease</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicida 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rafael Marin</i> | | | | 29c. LICENSE NUMBER 209293 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. RAFAEL MARIN - 3455 WILKENS AVENUE - SUITE 306 - BALTIMORE, MD. 21229 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1/4/94 | | | | 32. REGISTRAR'S SIGNATURE <i>John Sanderford</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, PER MEO FILM G-707 1/25/94 t.t

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00166

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIE MAE BENNETT | | | | 2. DATE OF DEATH MONTH 01 DAY 04 YEAR 94 | | 3. TIME OF DEATH 1:25 P.M. | |
| 4. SOCIAL SECURITY NUMBER 216-54-3517 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 44 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-30-1949 | |
| 9a. FACILITY NAME (If not institution, give street and number) 837 WHITE AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH LINTHICUM | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION LINTHICUM | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 837 WHITE AVENUE | | | |
| 10f. ZIP CODE 21090 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BAR MAID/MANAGER | | 16b. KIND OF BUSINESS/INDUSTRY LITTLE ERNIE'S PLACE TAVERN | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIE HENRY BABB | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EARLINE MYRA OWENS | | | |
| 19a. INFORMANT'S NAME (Type/Print) TAMMY R. BENNETT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3606 KELOX ROAD, BALTIMORE, MARYLAND 21207 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP CREMATORY 1/8 | | 20c. LOCATION — City or Town, State TOWSON, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. FATTY LIVER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. CHRONIC ALCOHOLISM DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 1-5-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. L. A. P. L. A. N. L. O. C. K. E. M. D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00167 | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES RANDOLPH BRANDON | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 3, 1994 | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER 228-52-1248 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 51 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) APRIL 29, 1942 | | 8. BIRTHPLACE (State or Foreign Country) S. BOSTON, VA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) VA MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH FORT HOWARD | | 9c. COUNTY OF DEATH BALTIMORE | | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE COUNTY | | 10c. CITY, TOWN OR LOCATION Turners Station | | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 118 CENTER STREET | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 4/11/67 to 5/31/70 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cab Driver | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHNNY SYDNOR | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY E. BRANDON | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dr. Mattie Lucas | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7928 Dunhill Village Circle, Balto., Md. 21244 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest V.A. 1/11 | | 20c. LOCATION — City or Town, State Owings Mills, Md. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i> | | | | 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARCINOMA OF LARYNX a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Lopez MD</i> | | | | 29c. LICENSE NUMBER D15932 | | 29d. DATE SIGNED (Month, Day, Year) Jan 3 1994 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAUL LOPEZ, M.D., VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | | | | | |

20190 90

James A. Smith

James A. Smith

DEPT. OF AGR.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


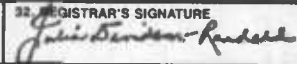
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00168

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WALTER M. BURDINSKI, Jr. | | | | 2. DATE OF DEATH MONTH 1 DAY 5 YEAR 94 | | 3. TIME OF DEATH 13:04 M | |
| 4. SOCIAL SECURITY NUMBER 212-05-8989 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10 29 16 | |
| 9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH JOHNS HOPKINS | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1205 HULL STREET | | | | 10f. ZIP CODE 21230-5238 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) ----- | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LONGSHOREMAN | | 15b. KIND OF BUSINESS/INDUSTRY WATERFRONT | | | |
| 17. FATHER'S NAME (First, Middle, Last) Walter M. Burdinski, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Stephanie Kycki | | | |
| 19a. INFORMANT'S NAME (Type/Print) Cecelia Burdinski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 Hull Street, Baltimore, MD 21230 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery | | DATE 1/8 | | 20c. LOCATION — City or Town, State Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore, MD 21230 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE GASTROINTESTINAL BLEEDING DUE TO (OR AS A CONSEQUENCE OF): b. DUODENAL ULCER DUE TO (OR AS A CONSEQUENCE OF): c. ACUTE RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death 10 days 10 days 10 days | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE CARDIOMYOPATHY FUNGAL SEPSIS | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Vasanthatha Rai P | | | | 29c. LICENSE NUMBER HOUSE STAFF | | 29d. DATE SIGNED (Month, Day, Year) ▶ | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D. V. RAI HARBOR HOSPITAL CENTER 3001 S. HANOVER | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

27

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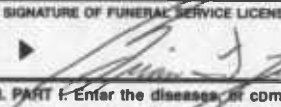
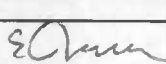

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00169

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Mary Josephine Bocek | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 4, 1994 | | 3. TIME OF DEATH 5:15 p. m | |
| 4. SOCIAL SECURITY NUMBER 220-44-5692 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 95 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 3, 1898 | |
| 9a. FACILITY NAME (If not institution, give street and number) Overlea Gardens Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Maryland | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY --- | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 812 N. Milton Avenue | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Klima | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Carolyn Shiminek | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charles Bocek (Son) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 N. Milton Avenue, Baltimore, Md. 21205 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. 1/8 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | 20d. DATE 1/8 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213 | | | |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular accident Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): Atrial Fibrillation c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D 30641 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Ramesh Sabapathi, 3400 Erdman Avenue, Baltimore, Md. 21213 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 94 00170

| | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Marie L. Brinkman</u> | | | | 2. DATE OF DEATH MONTH <u>01</u> DAY <u>06</u> YEAR <u>1994</u> | | 3. TIME OF DEATH <u>3 A</u> M | | | |
| 4. SOCIAL SECURITY NUMBER <u>218-09-1439</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>88</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>10-17-05</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>Baltimore</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Bon Secours Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u> | | | 9c. COUNTY OF DEATH <u>-</u> | | |
| 10a. STATE <u>MD</u> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <u>Baltimore City</u> | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER <u>2000 West Balt.</u> | | | | 10f. ZIP CODE <u>21223</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: <u>white</u> | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u>-</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u> | | | 16b. KIND OF BUSINESS/INDUSTRY <u>Self</u> | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>George E. Gettier</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Agnes Herring</u> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>R. Reid Brinkman</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1022 Wilmington Avenue, Baltimore, Maryland 21223</u> | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Lorraine Park Cemetery</u> | | 20c. LOCATION — City or Town, State <u>Woodlawn, Maryland</u> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227</u> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Acute Congestive Heart Failure</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>Dilated Cardiomyopathy</u> c. <u>Arteriosclerotic Heart Disease</u> d. <u>-</u> | | | | | | | | Approximate Interval Between Onset and Death <u>1 DAY</u> <u>Years</u> <u>Years</u> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>MIOPD</u> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <u>-</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dr. Mark Levine MD</u> | | | | 29c. LICENSE NUMBER <u>023020</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>1-6-94</u> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>DR MARK LEVINE BON Secours Hospital</u> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 07 1994</u> | | 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |

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27100 42

94 00171

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DOUGLAS B. BRADY, SR. | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 2, 1994 | | | | 3. TIME OF DEATH 1:20 P. M. | | | |
| 4. SOCIAL SECURITY NUMBER 217-01-4041 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JAN. 1, 1914 | | 8. BIRTHPLACE (State or Foreign Country) SUMMIT POINT, W. VA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 800 UNETTA AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 800 UNETTA AVENUE | | | | 10f. ZIP CODE 21229-4608 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ASSISTANT GAUGER | | 16b. KIND OF BUSINESS/INDUSTRY BETHLEHEM STEEL | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) OSCAR W. BRADY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JENNIE E. BOYD | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) DOUGLAS B. BRADY, JR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 UNETTA AVENUE - BALTIMORE, MD. 21229 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK MAUSOLEUM 1/6 | | DATE 1/6 | | 20c. LOCATION — City or Town, State BALTIMORE | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. Leaf Colman</i> | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Bronchitis</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph H Miller MD</i> | | | | 29c. LICENSE NUMBER D06982 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH H MILLER MD 900 CATON AVE Baltimore Md 21229 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Benjamin Fendall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00172

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) Ida G. Brown | | | | 2. DATE OF DEATH MONTH DAY YEAR January 2, 1994 | | 3. TIME OF DEATH 11:30 P M | | | | |
| 4. SOCIAL SECURITY NUMBER 214 14 0920 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 14, 1921 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number) 1214 W. 36th Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH Baltimore City | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1214 W. 36th Street | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Sherman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Bowen | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Patricia M. Barton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 4405 Mary Avenue, Baltimore, MD 21206 | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) LakeView Memorial 1/5/94 | | 20c. LOCATION — City or Town, State Sykesville, MD | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Walter J. Henss</i> | | | | 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home, P.A. 3631 Falls Road, Baltimore, MD 21211 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>metastatic gastric carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>June E. Breiner MD</i> | | | | 29c. LICENSE NUMBER 040208 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/93 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. June E. Breiner, 1205 York Road, Lutherville, Maryland | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | 32. REGISTRAR'S SIGNATURE <i>John S. Anderson-Randall</i> | | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00173 | |
|--|--|---|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Turner Cecil BARTLETT | | | | 2. DATE OF DEATH MONTH DAY YEAR January 3, 1994 | | | | 3. TIME OF DEATH 10:32 A M | |
| 4. SOCIAL SECURITY NUMBER 212-34-1911 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-12-1931 | | 8. BIRTHPLACE (State or Foreign Country) Tennessee | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | | | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Middle River | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 13212 Choptank Road | | | | 10f. ZIP CODE 21220 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES U.S. Navy | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) G.E.D. College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervision | | 16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel Corp. | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Marvin Delbert Bartlett | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lydia Aileen Haley | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Audra W. Bartlett | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13212 Choptank Road Middle River, MD 21220 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Cem. 1/7/94 | | 20c. LOCATION — City or Town, State Dorsey, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Scott C. Brun, MD | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Scott C. Brun, MD 9000 Franklin Square Dr., Balto., MD 21237 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00174

| | | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BERTHA CHANDLER | | | | 2. DATE OF DEATH MONTH JANUARY DAY 4 YEAR 1994 | | 3. TIME OF DEATH 5:55P M | | | | |
| 4. SOCIAL SECURITY NUMBER 212-22-9198 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-7-12 | | 8. BIRTHPLACE (State or Foreign Country) S.C. | | |
| 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTO MEDICAL HOSP | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO | | | | 9c. COUNTY OF DEATH | | |
| 10a. STATE MD | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTO | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 1910 BRADDISH AVE | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH College (14 or 5+) DIETIAN | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DIETIAN | | 16b. KIND OF BUSINESS/INDUSTRY SOUTH BALTO GEN HOSP | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN MCCRAE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ROVINA JONES | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) PATRICIA TUCKER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 HUN TSMANRD BALTO, MD 21286 | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY | | DATE 1894 | | 20c. LOCATION — City or Town, State Towson, MD | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia Tucker</i> | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H WEST 4300 WABASH AVE | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONITIS Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. SEPTICEMIA c. RESPIRATORY FAILURE d. | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TYPE II DM, PERIPHERAL VASCULAR DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Raymond A. Nze MD | | | | 29c. LICENSE NUMBER D34184 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7801 YORK RD #300 TOWSON MD 21204 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John D. Harrison-Randall</i> | | | | | | |

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00175

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM David CLAYTON Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 05, 1994 | | 3. TIME OF DEATH 00:20 M | |
| 4. SOCIAL SECURITY NUMBER 216-18-0291 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH Month Day Year 12/27/24 | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Timonium | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 305 Quaker Ridge Road | | | | 10f. ZIP CODE 21093 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 + | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Financial Officer | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) William David Clayton Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Hessenauer | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jean M. Clayton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Quaker Ridge Road, Timonium, Md. 21093 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. | | DATE 1/6/94 | | 20c. LOCATION — City or Town, State Towson, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James J. Bladden | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Inc. 5305 Hartford Rd. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Sustenauer MD | | | | 29c. LICENSE NUMBER D00875 | | 29d. DATE SIGNED (Month, Day, Year) 01/05/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rudiger Breiteneker, M.D. - GBMC 6701 N Charles St; Towson MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 06 1994 | | | | 32. REGISTRAR'S SIGNATURE John D. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00176

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eleanora Caroline COX | | | | 2. DATE OF DEATH MONTH DAY YEAR January 3 1994 | | 3. TIME OF DEATH 11:00 p.m. | |
| 4. SOCIAL SECURITY NUMBER 200-10-3100 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 101 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-23-1892 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH Rossville | | | | 11. COUNTY OF DEATH Baltimore | | | |
| 12a. STATE Maryland | | 12b. COUNTY Baltimore | | 12c. CITY, TOWN OR LOCATION Dundalk | | 12d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 13. STREET AND NUMBER 3600 Old North Point Road | | | | 14. ZIP CODE 21222 | | 15. CITIZEN OF WHAT COUNTRY? United States | |
| 16. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 19. RACE — American Indian, Black, White, etc. Specify: White | |
| 20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th Grade | | 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 22. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 23. FATHER'S NAME (First, Middle, Last) Julius Waire | | | | 24. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Boger | | | |
| 25. INFORMANT'S NAME (Type/Print) Mrs. Laura M. Gubernatis | | | | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1544 Glen Keith Blvd. Towson, Maryland 21286 | | | |
| 27a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 27b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 1/5/94 | | 27c. LOCATION — City or Town, State Towson, Maryland | | | |
| 28. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 29. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| 30. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Aspiration DUE TO (OR AS A CONSEQUENCE OF): c. Cerebral vascular accident DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| 31. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 32a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 32b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 33. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 34. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 35. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 36. DATE OF INJURY (Month, Day, Year) | | 37. TIME OF INJURY M | | 38. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 39. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 40. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 41. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 42. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 43. SIGNATURE AND TITLE OF CERTIFIER | | | | 44. LICENSE NUMBER | | 45. DATE SIGNED (Month, Day, Year) | |
| 46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Harold Cohen M.D. 9000 Franklin Square Drive, Baltimore, MD 21237 | | | | | | | |
| 47. DATE FILED (Month, Day, Year) JAN 07 1994 | | 48. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00177

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Harvey B. Dunkle-Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR January 4 1994 | | 3. TIME OF DEATH 10:29 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-20-6882 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-17-1925 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) The Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE Maryland | | 10b. COUNTY -- | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3659 Malden Avenue | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 8+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman | | 16b. KIND OF BUSINESS/INDUSTRY Upolstry Fabric | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Harvey B. Dunkle, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy P. Dunkle | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3659 Malden Avenue Baltimore, MD 21211 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery 1/7 | | 20c. LOCATION — City or Town, State Woodlawn, MD | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Burpee-Henss Carpenter</i> | | | | 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road Balto., MD 21211 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCT DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 1 Hr 30 minutes | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE DIFFUSE INTERSTITIAL LUNG DISEASE | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jonathan R. P. M.D.</i> | | | | | | 29c. LICENSE NUMBER DA AT2438946E12 | | 29d. DATE SIGNED (Month, Day, Year) JANUARY 4, 1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANTONIO PASTOR M.D. 201 EAST UNIVERSITY PARKWAY, BALTIMORE MD 21218 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Benson-Randall</i> | | | | | | | |

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00178 | |
|--|--|--|--|---|--|---|---|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED'S NAME (First, Middle, Last) Hazel | | Ethridge | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 6 1994 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 215-16-5355 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/10/12 | |
| 8. BIRTHPLACE (State or Foreign Country) MD | | 9a. FACILITY NAME (If not institution, give street and number) Mercy Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4820 Orville Ave. | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Fick | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Nancy Kurzmillner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1803 GREENCASTLE DR. BALTO. MD 21237 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lakeview Memorial 1/10/94 | | 20c. LOCATION — City or Town, State SYKESVILLE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis S. Kelly | | 22. NAME AND ADDRESS OF FACILITY Cvach/Rosedale Funeral Home 1211 Chesaco Ave. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Renal Failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Diarrhea | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Fernando J. Ferro MD | | | | | |
| 29c. LICENSE NUMBER D40480 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FERNANDO J. FERRO, MD 5810 BELAIR RD. BALTIMORE, MD 21206 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez | | | | | |

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00179

| | | | | | | | | | | |
|---|--|--|--|---|--------------------------|---|--|---|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JUNIOUS EDWARDS | | | | | | 2. DATE OF DEATH MONTH 01 DAY 04 YEAR 94 | | 3. TIME OF DEATH M | | |
| 4. SOCIAL SECURITY NUMBER 224-18-8745 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-21-18 | | 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH NONE | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY NONE | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 2574 CECIL AVENUE | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: AFRICAN AMERICAN | | | 14. RACE — American Indian, Black, White, etc. Specify: | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) NONE | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CRANE OPERATOR | | 15b. KIND OF BUSINESS/INDUSTRY BETHLEHEM STEEL | | | | |
| 17. FATHER'S NAME (First, Middle, Last) NATHANIEL EDWARDS | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CEDONIA PRETLOW | | | | |
| 19a. INFORMANT'S NAME (Type/Print) REBECCA EDWARDS | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2574 CECIL AVENUE BALTIMORE, MARYLAND 21218 | | | | |
| 20a. METHOD OF DISPOSITION X <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE LOUDON PARK CEMETERY 1/11/94 BALTO., MARYLAND | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET, BALTO, MD. 21211 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SHOCK DUE TO (OR AS A CONSEQUENCE OF): b. ATRIAL FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | Approximate Interval Between Onset and Death 3 | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALZHEIMERS DISEASE | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>JMh MD</i> | | | | | | 29c. LICENSE NUMBER D27437 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN WOGAN, MD, UNION MEMORIAL HOSPITAL | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

11/11/54

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. 94 00180 | | | |
|--|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Mary A. Ficca | | | | 2. DATE OF DEATH MONTH 4 DAY 1994 YEAR | | 3. TIME OF DEATH M | | | |
| 4. SOCIAL SECURITY NUMBER 216-36-4040 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/4/08 | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH MD | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Edgemere | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 8800 Millers Island Rd. | | | | 10f. ZIP CODE 21219 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 6 College (1-4 or 5+) / | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales | | 16b. KIND OF BUSINESS/INDUSTRY Belair Market | | | |
| 17. FATHER'S NAME (First, Middle, Last) DeLegge | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Glenn Brown | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Millers Island Rd. Edgemere, MD 21219 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial 1/8/94 | | 20c. LOCATION — City or Town, State Baltimore, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Denis S. Kelly</i> | | | | 22. NAME AND ADDRESS OF FACILITY Cvach/Rosedale Funeral Home 1211 Chesaco Ave. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Ischemic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death years. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD</i> | | | | | |
| 29c. LICENSE NUMBER 030377 | | | | 29d. DATE SIGNED (Month, Day, Year) Jan 6, 94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert M. Cooper MD 100 N. Broadway BALTO MD 21231 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John S. Borden</i> | | | | | |

06100 49

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00181

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Anna Frederick Anna C. Frederick | | | | 2. DATE OF DEATH MONTH 1 DAY 2 YEAR 94 | | 3. TIME OF DEATH 6:15 P M | |
| 4. SOCIAL SECURITY NUMBER 219-14-1600 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/29/08 | |
| 9a. FACILITY NAME (If not institution, give street and number) Meridian Nsg Center Hamilton | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto, Md. | | 9c. COUNTY OF DEATH ----- | |
| 10a. STATE Maryland | | 10b. COUNTY ----- | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3304 Clifftmont Ave. | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (14 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) August Denford | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily Wirts | | | |
| 19a. INFORMANT'S NAME (Type/Print) John Buscemi (Nephew) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4043 A. Born Road, Jarrettsville, Md. 21084 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 1/4 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert J. Salas | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Depression | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Ferdinand Ferro | | | | 29c. LICENSE NUMBER D40480 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Ferdinand Ferro, 5810 Belair Road, Baltimore, Md. 21206 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE Julius Benson-Randall | | | |

151-22

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00182

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Agnes C. Foti | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 4, 1994 | | 3. TIME OF DEATH 2:20 P.M. | | | |
| 4. SOCIAL SECURITY NUMBER 215-64-1238 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 2, 1918 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 9400 Oak White Road | | | | 10f. ZIP CODE 21236 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Breslin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Markham | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Theodore F. Foti, Sr. (husband) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9400 Oak White Road, Baltimore, MD 21236 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory | | DATE | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>Sudden Death</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Coronary art. disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate interval Between Onset and Death 5 min | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 020390 | | 29d. DATE SIGNED (Month, Day, Year) 11/6/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Charles F. Hoesch, 9712 Belair Rd., Suite 203, Baltimore, MD 21236 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is checked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00183 | |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | |
| MARY VIRGINIA GOTT | | | | 01 04 94 | | | | 2:15 A. M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | |
| 217-09-1101 | | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 89 YRS. | | 03 29 04 | | VIRGINIA | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | |
| ST. JOSEPH HOSPITAL | | | | TOWSON | | | | BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | |
| 10a. STATE | | 10b. COUNTY | | BALTIMORE | | | | <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| MARYLAND | | -- | | | | | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 5205 CATALPHA ROAD | | | | 21214 | | USA | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | Specify: WHITE | | | |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | IF YES, GIVE WAR OR DATES | | Specify: | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12) 8TH | | | | College (1-4 or 5+) HOUSEWIFE | | -- | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| WILLIAM POWELL | | | | M. ESTELL ASHBURN | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| LELIA MILLS | | | | 5205 CATALPHA ROAD, BALTIMORE, MARYLAND 21214 | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | | GOOD SHEPHERD CEMETERY 1/6/94 | | 1/6/94 | | ELLICOTT CITY, MD. | | | |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | |
| <i>Donald G. Wright, Jr.</i> | | | | A. ALAN SEITZ, JR. FUNERAL HOME 21211 | | | | | |
| | | | | 3818 ROLAND AVENUE, BALTIMORE, MARYLAND | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Gastrointestinal bleeding</i> | | | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| <i>Cancer colon</i> | | | | | | | | | |
| <i>Hip fracture</i> | | | | | | | | | |
| <i>Myocardial infarction</i> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | 24a. WAS AN AUTOPSY PERFORMED? | |
| 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 12/13/93 | | | | UNK | |
| 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| | | | | Home | | | | 5205 CATALPHA ROAD | |
| 29a. CERTIFIER (Check only one) | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 1/15504 | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29d. DATE SIGNED (Month, Day, Year) | |
| | | | | | | | | 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | |
| E. N. NICHOLS MD 2300 Delany Valley Rd 21204 | | | | JAN 07 1994 | | | | <i>John S. Anderson-Randall</i> | |

General Building

2002 CATALAN (P4)
1177 House X

2002 House X
1177

2002 House X
1177

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

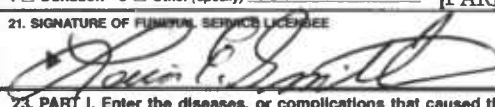
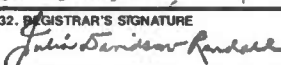
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 94 00184 | |
|---|--|--|--|---|---|---|--|---|---|---|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH L. GOECKE | | | | | | 2. DATE OF DEATH MONTH 1 DAY 3 YEAR 94 | | 3. TIME OF DEATH 10-25 A.M. | | | |
| 4. SOCIAL SECURITY NUMBER 215-10-5066 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 25, 1915 | | 8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. MARTINS HOME | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE | | | 9c. COUNTY OF DEATH BALTIMORE | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY TALBOT | | 10c. CITY, TOWN OR LOCATION TILGHMAN | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER P.O. BOX 261 | | | | 10f. ZIP CODE 21671 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 YRS College (1-4 or 5+) 2 YRS | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SHIPBUILDER | | | | 16b. KIND OF BUSINESS/INDUSTRY CO. MD SHIPBUILDING & DRYDOCK | | | |
| 17. FATHER'S NAME (First, Middle, Last) OTTO P. GOECKE | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JUSTINA M. ROHLEDER | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) ANNA A. GOECKE | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 MAIDEN CHOICE LANE-CATONSVILLE, MD, 21228 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY | | | | 20c. LOCATION — City or Town, State BALTIMORE | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD, 21229 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF): c. ATHEROSCLEROTIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMPTY STOMA | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John E. Smith MD | | | | | | 29c. LICENSE NUMBER 021649 | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAM BANDA BASKARAN 3455 Wilkens Ave Baltimore MD 21229 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ELSIE C. HILL | | | | 2. DATE OF DEATH MONTH 1 DAY 5 YEAR 94 | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER 220-44-5012 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 96 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-19-1897 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Edenwald-800 Southerly Rd. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | | 9c. COUNTY OF DEATH Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 800 Southerly Rd. | | | | 10f. ZIP CODE 21286 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 yrs | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 15b. KIND OF BUSINESS/INDUSTRY Own Home | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Clifford Gettier | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothea Schott | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Catherine H. Ehrhardt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10321 A Malcolm Cir. Cockeysville, Md. 21030 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery | | DATE 1-7 | | 20c. LOCATION — City or Town, State Parkville, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): b. Left Atrial Myxoma DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Iron deficiency anemia. Osteoarthritis | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D34124 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. John Milto 7600 Osler Dr. Towson, Md. 21204 Suite 213 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00186

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LEONA HILLMAN | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 22-10 M | | | | | |
| 4. SOCIAL SECURITY NUMBER 212 204880 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/23/26 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH N/A | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION BROOKLYN PARK | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 104 WEST CEDAR HILL ROAD | | | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) NONE | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | | 16b. KIND OF BUSINESS/INDUSTRY OWN HOME | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) ELMER HARTLOVE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) NANNIE MARSH | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) EARL L. HILLMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 WEST CEDAR HILL ROAD, BALTIMORE, MD. 21225 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) GLEN HAVEN MEMORIAL PARK | | DATE 1994 | | 20c. LOCATION — City or Town, State GLEN BURNIE, MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MD. 21061 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac arrhythmia</u> DUE TO (OR AS A CONSEQUENCE OF): b. — DUE TO (OR AS A CONSEQUENCE OF): c. — DUE TO (OR AS A CONSEQUENCE OF): d. — Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Ditayadut Jum RUSORIKUL | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | |

23100. 42

23100. 42

23100. 42

23100. 42

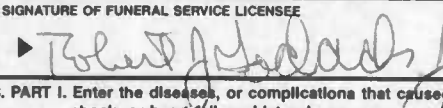
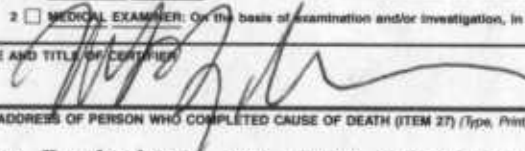
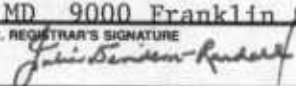
ADDITIONAL

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 001871

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Thelma Elizabeth HAMMOND | | | | 2. DATE OF DEATH MONTH DAY YEAR January 3, 1994 | | 3. TIME OF DEATH 7:35 A M | |
| 4. SOCIAL SECURITY NUMBER 231-96-0255 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 28, 1908 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 11. COUNTY OF DEATH Baltimore | | | |
| 12a. STATE Maryland | | 12b. COUNTY Baltimore | | 12c. CITY, TOWN OR LOCATION Perry Hall | | 12d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 13. STREET AND NUMBER 9905 Forge Park Road | | | | 14. ZIP CODE 21128 | | 15. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 16. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 19. RACE — American Indian, Black, White, etc. Specify: White | |
| 20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) N/A College (1-4 or 5+) N/A | | 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 22. KIND OF BUSINESS/INDUSTRY Own home | | | |
| 23. FATHER'S NAME (First, Middle, Last) William Luther Coleman | | | | 24. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Smith | | | |
| 25. INFORMANT'S NAME (Type/Print) Gerald R. Hammond (Son) | | | | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9905 Forge Park Road, Perry Hall, Md. 21128 | | | |
| 27a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 27b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New St. Joseph Cemetery | | 27c. DATE 1/7 | | 27d. LOCATION — City or Town, State Emmitsburg, Maryland | |
| 28. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 29. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Road, Baltimore, Md. 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D27315 | | 29d. DATE SIGNED (Month, Day, Year) 1-3-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. Lan Frydenborg, MD 9000 Franklin Square Drive, Balto., Md. 21162 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00189

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Oreatha J. HENSLEY | | | | 2. DATE OF DEATH MONTH DAY YEAR January 5, 1994 | | 3. TIME OF DEATH 9:05 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 412-30-3005 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 01 13 22 | | 8. BIRTHPLACE (State or Foreign Country) TENNESSEE | | | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ROSEDALE | | | 9c. COUNTY OF DEATH BALTIMORE | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 255 Orville Road | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 YRS. | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) WALTER BIRD ROACH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SALLIE OREATHA MILLER | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MILTON HENSLEY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1515 ALCONBURY ROAD, BALTIMORE, MARYLAND 21221 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CREST LAWN MEMORIAL GDNS 1/7/94 | | DATE 1/7/94 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE A. Alan Seitz, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY A. ALAN SEITZ, JR. FUNERAL HOME 21211 3818 ROLAND AVENUE, BALTIMORE, MARYLAND | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): b. myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Stanley Z. Pelisberg M.D. M.D. Examiner | | | | 29c. LICENSE NUMBER 001085 | | 29d. DATE SIGNED (Month, Day, Year) Jan 8, 1994 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stanley Z. Pelisberg M.D. 11 E. Charles St. Baltimore, MD | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE John Dandekar-Randall | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00190

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Theresa Lee Hartman | | | | 2. DATE OF DEATH MONTH 1 DAY 5 YEAR 94 | | 3. TIME OF DEATH 8:34 AM | | | | | |
| 4. SOCIAL SECURITY NUMBER 218-14-5980 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT. 1, 1925 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | | 9c. COUNTY OF DEATH Baltimore | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY HARFORD | | 10c. CITY, TOWN OR LOCATION EDGEWOOD | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 601 SORRELWOOD COURT | | | | 10f. ZIP CODE 21040 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) H/S GRAD College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY | | 16b. KIND OF BUSINESS/INDUSTRY DR. RAMSEY THOMAS | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) CARROLL R. PHILLIPS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA PARROTT | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOHN C. HARTMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 SORRELWOOD COURT-EDGEWOOD, MD. 21040 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUBON PARK CEMETERY | | DATE 1/8 | | 20c. LOCATION — City or Town, State BALTIMORE | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEPATIC FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. CIRRHOSIS OF LIVER DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death 3 mos. Unknown | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R. Faulkner, M.D. | | 29c. LICENSE NUMBER D25643 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kendall R. Faulkner, M.D., 2300 Dulaney Valley Road, Towson, Maryland 21204 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | 32. REGISTRAR'S SIGNATURE John Sanderson-Randall | | | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH MONTH DAY YEAR | | | | 3. TIME OF DEATH | |
|---|--|---|--|---|--|--|--|---|--|
| MYRTLE INEZ HUDSON | | | | JAN 02, 1994 | | | | 9:48 A. M. | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) | |
| 213-26-0785 | | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 63 YRS. | | NOV. 8, 1930 | | VIRGINIA | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | |
| #2 14th AVENUE | | | | BALTIMORE (BROOKLYN) | | | | ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | |
| MARYLAND | | | | BALTIMORE | | | | <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | |
| #2 14th AVENUE | | | | 21225 | | | | U.S.A. | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | | | | 14. RACE — American Indian, Black, White, etc. | |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | Specify: WHITE | |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | IF YES, GIVE WAR OR DATES | | Specify: | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | | | SWITCHBOARD OPERATOR | | | | CATONSVILLE COMMUNITY COLLEGE | |
| H/S GRAD | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| HARRY WOODY | | | | FLARRY BEASLEY | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| MAURICE E. HUDSON, JR. | | | | #2- 14th AVENUE- BALTIMORE, MD. 21225 | | | | | |
| 20a. METHOD OF DISPOSITION | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | 20c. LOCATION — City or Town, State | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | | | | MEADOWRIDGE MEMORIAL PK 1/6 | | | | ELKRIDGE, MD. | |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | |
| | | | | HUBBARD FUNERAL HOME INC. | | | | | |
| | | | | 4107 WILKENS AVENUE- BALTIMORE, MD. 21229 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | |
| a. Metastasis | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| b. Cancer Lung | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| c. | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| d. | | | | | | | | | |
| Approximate Interval Between Onset and Death | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? | | | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | | | | | | | | |
| OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH | | | | | | | | | |
| 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation | | | | | | | | | |
| 2 <input type="checkbox"/> Accident | | | | | | | | | |
| 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined | | | | | | | | | |
| 4 <input type="checkbox"/> Homicide | | | | | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | | | | | | |
| 28b. TIME OF INJURY | | | | | | | | | |
| 28c. INJURY AT WORK? | | | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | | | | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | | |
| MD | | | | | | | | | |
| 29c. LICENSE NUMBER | | | | | | | | | |
| D17743 | | | | | | | | | |
| 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | |
| 1-3-94 | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| DR. LASHMIPATHY SEENIVASAN - 606 HAMMONDS LANE- BALTIMORE, MD. 21225 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | | | | | | |
| JAN 07 1994 | | | | | | | | | |
| 32. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | | | | | | | | | |

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00192

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>CLARA A. HATCHETT</i> Clara Hatchett | | | | 2. DATE OF DEATH MONTH <i>01</i> DAY <i>05</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>12:47 P M</i> | |
| 4. SOCIAL SECURITY NUMBER 215-24-3346 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-28-1906 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Maryland | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1063 Ellicott Dr. | |
| 10f. ZIP CODE 21216 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) John S. McNeill | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Alice Harrington | | | |
| 19a. INFORMANT'S NAME (Type/Print) Nettie R. Harrison | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 147 Patchen Ave. Bklyn. N.Y. 11221 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. National Mem. Pk. 1-8 Laurel, Md. | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Carlton C. Douglas</i> | | | | 22. NAME AND ADDRESS OF FACILITY Douglass Funeral Service 1701 McCulloh St. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Hypertension / Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c. ASCVD</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d. Massive Stroke</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. J. GLOTH DO</i> | | | | 29c. LICENSE NUMBER <i>2402381</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/5/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MARK J GLOTH DO SINAI HOSPITAL</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>J. A. Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00100 40

00100 40

00100 40

00100 40

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00193

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN PAUL JONES (JOHN PAUL JONES) | | | | 2. DATE OF DEATH MONTH 1 DAY 5 YEAR 94 | | 3. TIME OF DEATH 12:11 AM | |
| 4. SOCIAL SECURITY NUMBER 220-03-8165 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08-23-21 | |
| 8. BIRTHPLACE (State or Foreign Country) NORTH CAROLINA | | | | 9. COUNTY OF DEATH NONE | | | |
| 9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH NONE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY NONE | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1224 KITMORE AVENUE | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 03-26-43-10-22-45 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: X | | 14. RACE — American Indian, Black, White, etc. Specify: AFRICAN AMERICAN | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4TH College (1-4 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ORDERLY | | 16b. KIND OF BUSINESS/INDUSTRY UNIVERSITY HOSPITAL | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAKE RAMSEY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CONSTANCE JONES | | | |
| 19a. INFORMANT'S NAME (Type/Print) PAUL JONES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1519 E. BIDDLE ST. BALTO, MD. 21213 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VETERANS CEM./OWINGS MILLS, MD. | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs, Jr.</i> | | 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST (CARDIAC ARREST) Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. CORONARY ARTERY DISEASE (CORONARY ARTERY DISEASE) c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D08340 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

39100 49

4-10-1954

15X4000

Handwritten signature and date: 10/10/54



1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00194

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SHIRLEY MARIE KNAUS | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 5, 1994 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 215-30-2491 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JAN. 4, 1934 | |
| 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION GLEN BURNIE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 809 DALE ROAD | | | | 10f. ZIP CODE 21060 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY/CLERK | | 16b. KIND OF BUSINESS/INDUSTRY MD. MEDICAL LAB. | | | |
| 17. FATHER'S NAME (First, Middle, Last) GEORGE SCHRODETZKI | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA DOUGHTY | | | |
| 19a. INFORMANT'S NAME (Type/Print) HENRY A. KNAUS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 DALE ROAD, GLEN BURNIE, MARYLAND 21060 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) CEDAR HILL | | 20c. LOCATION — City or Town, State BROOKLYN PARK, MD. | | 20d. DATE 1994 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Anoxic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Aspiration of Foreign Body DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 26d. DESCRIBE HOW INJURY OCCURRED | | | | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 26g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER MD2664 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Young-Hyman, M.D., 1600 Green Hill, Glen Burnie, MD 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is completed, it must be filed with the funeral director, who is responsible for its filing with the State Registrar of Death and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. 94 00195 | |
|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Catharina A. Kimmerle</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>9</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>4:20 P. M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>217096035</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>78</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>12/11/15</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Washington, D.C.</i> | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Church Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH <i>City</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>---</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>603 S. Ann St.</i> | | | | 10f. ZIP CODE <i>21231</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>n/a</i> College (1-4 or 5+) <i>n/a</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Inspector</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Bendix Corporation</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Bartholomew A. Blair</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Miriam Donald</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Miriam Brooks (Dghtr)</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>49 Stemmers Run Road, Baltimore, Md. 21221</i> | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>Entombment</i> | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Moreland Memorial Park</i> | | DATE <i>1/4/94</i> | | 20c. LOCATION — City or Town, State <i>Baltimore, Md.</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Bilateral Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death <i>28 days</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Sep h'emia</i> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] M.D.</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MANSOUR MATHMOOD 2406 VILLAGE DRIVE ARLING HEIGHTS MD 21011</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 07 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

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JAN 10 1964
U.S. AIR FORCE
HONOLULU
HAWAII



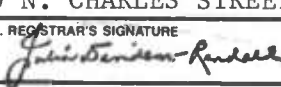
TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report with several paragraphs.]

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00196

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY J. KING | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 06 1994 | | 3. TIME OF DEATH 7:30 P. M. | |
| 4. SOCIAL SECURITY NUMBER 212-07-1862 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 02 20 05 | |
| 9a. FACILITY NAME (If not institution, give street and number) MERIDIAN - LONG GREEN | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH --- | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY --- | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 115 E. MELROSE AVENUE | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) --- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SEAMSTRESS | | 16b. KIND OF BUSINESS/INDUSTRY CLOTHING | | | |
| 17. FATHER'S NAME (First, Middle, Last) (?) STINCHECUM | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARY ROBINSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 W. 36th STREET, BALTIMORE, MARYLAND 21211 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CEMETERY 1/10/94 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY A. ALAN SEITZ, JR. FUNERAL HOME 21211 3818 ROLAND AVENUE, BALTIMORE, MARYLAND | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Influenza</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Cerebrovascular Accident</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  M.D. | | | | 29c. LICENSE NUMBER D33897 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. VISSING 4300 N. CHARLES STREET, APT. G, BALTIMORE, MARYLAND 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|--|---|--------------------------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHRISTOPHER DAVID KRABY <i>CHRISTOPHER KRABY</i> | | | | | 2. DATE OF DEATH MONTH 1 DAY 1 YEAR 94 | | 3. TIME OF DEATH 5:55 P.M. | | | | |
| 4. SOCIAL SECURITY NUMBER 576-11-8402 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 18 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 5 11 75 | | 8. BIRTHPLACE (State or Foreign Country) ALABAMA | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>University of Maryland Hosp.</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH <i>Balt. City</i> | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY TALBOT Talbot | | 10c. CITY, TOWN OR LOCATION EASTON | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 1200 S. WASHINGTON STREET-APT. 1108 | | | | 10f. ZIP CODE 21601 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE, 11th College (1-4 or 5+) STUDENT | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STUDENT | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) DAVID A. KRABY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JO LYNNE M. PREKKER | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) DAVID KRABY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 S. WASHINGTON STREET, APT. 1108-EASTON, MD 21601 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FT. SNELLING | | OATE 1/7/94 | | 20c. LOCATION — City or Town, State St. Paul, Minn. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dawn Z Fisher</i> | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>cerebral edema.</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>subarachnoid hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] - Neurosurgeon</i> | | | | | | 29c. LICENSE NUMBER 5569 | | 29d. DATE SIGNED (Month, Day, Year) 1/1/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Print, Last, First, Middle) LEON, LISA M. M.D. | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00198 | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) <u>LAMB DIN HAZEL ALBERTA LAMBDIN</u> | | | | 2. DATE OF DEATH MONTH DAY YEAR <u>JANUARY 5, 1994</u> | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER <u>214-20-3501</u> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>93</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>FEB. 13, 1900</u> | | | | | |
| 8. BIRTHPLACE (State or Foreign Country) <u>MARYLAND</u> | | | | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>HARBOR HOSPITAL CENTER</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u> | | 9c. COUNTY OF DEATH <u>N/A</u> | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE <u>MARYLAND</u> | | 10b. COUNTY <u>ANNE ARUNDEL</u> | | 10c. CITY, TOWN OR LOCATION <u>GLEN BURNIE</u> | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER <u>964 PRINCETON TERRACE</u> | | | | 10f. ZIP CODE <u>21060</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u>NONE</u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>ASSEMBLY LINE</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>FEDERAL TIN COMPANY</u> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>ALBERT FLEURY</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>LOUISE CONWAY</u> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>LOIS J. BLOODSWORTH</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>964 PRINCETON TERRACE, GLEN BURNIE, MARYLAND 21060</u> | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>GLEN HAVEN MEMORIAL PARK</u> DATE <u>1994</u> | | 20c. LOCATION — City or Town, State <u>GLEN BURNIE, MARYLAND</u> | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</u> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>SEPSIS</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>SMALL BOWEL OBSTRUCTION</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>VALVULAR HEART Disease</u> <u>CORONARY ARTERY Disease</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u> Attending | | | | 29c. LICENSE NUMBER <u>D21776</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>1/5/94</u> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>SOLITA P. MUNORA MD 203 E- PARATSCO AV. BALTIMORE MD 21225</u> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 07 1994</u> | | | | 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |

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SECTION FIVE

SECTION FIVE

SECTION FIVE



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ANDREW LAWYER | | | | | | 2. DATE OF DEATH MONTH 01 DAY 04 YEAR 94 | | 3. TIME OF DEATH 6:23 P.M. | | |
| 4. SOCIAL SECURITY NUMBER 579-52-8357 | | 5. SEX 1 M 2 F | 6. AGE (In yrs. last birthday) 54 47 YRS. | 7. DATE OF BIRTH MONTH 07 DAY 28 YEAR 1939 | | 8. BIRTHPLACE (State or Foreign Country) FLORIDA | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANCES SCOTT KEY MEDICAL CENTER | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| 10e. STREET AND NUMBER 5764 CEDONIA AVENUE apt. C. | | | | 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A | | | 16b. KIND OF BUSINESS/INDUSTRY HOTEL | | | | |
| 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EFFIE | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) ANGELA LAWYER | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4203 ILLINOIS AVE. N.W./WASHINGTON, D.C. 20010 | | | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CEMETERY | | DATE | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Angela Bond | | | | | 22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVENUE | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 78% BURN Diabetes Cocaine use - possibly | | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Cocaine use - possibly | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 Could not be determined 3 Suicide 4 Homicide | | | 28a. DATE OF INJURY (Month, Day, Year) 1-1-94 | | 28b. TIME OF INJURY 130A M | | 28c. INJURY AT WORK? 1 YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED HOUSE FIRE | |
| | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1317 Wilcox Balt. MD | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Mark A. Person DO | | | 29c. LICENSE NUMBER 05007798 L | | 29d. DATE, SIGNED (Month, Day, Year) 1/4/94 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10 FRANCES SCOTT KEY MED CTR 4940 EASTERN AVE BALTIMORE | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1/4/94 | | | 32. REGISTRAR'S SIGNATURE Julie Benison-Randall | | | | | | | |

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00200

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Delbert B. Lease, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 05, 1994 | | 3. TIME OF DEATH M | | | |
| 4. SOCIAL SECURITY NUMBER 220-32-4254 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06/21/36 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) 1260 June Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Arbutus | | | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE MD | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Arbutus, | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1260 June Road | | | | 10f. ZIP CODE 21227 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: no | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreman | | 16b. KIND OF BUSINESS/INDUSTRY County Government | | | |
| 17. FATHER'S NAME (First, Middle, Last) Delbert Belmont Lease, Sr | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Meyers | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Yvonne Brown Lease | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1260 June Road Arbutus MD 21227 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest | | DATE 1/10 | | 20c. LOCATION — City or Town, State Cumberland, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FUNERAL HOME Ambrose Funeral Home 1328 Sulphur Spring Road, Arbutus, MD | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic lung cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death 18 mon | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Charles Padgett MD | | | | 29c. LICENSE NUMBER D15546 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type, Print) Charles Padgett MD 5601 Loch Raven Blvd. Baltimore MD 21239 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | 32. REGISTRAR'S SIGNATURE Johanna Davidson-Randall | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00202

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MORRIS JAMES James A. Morris | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 04 1994 | | 3. TIME OF DEATH 2:13 a.m. | |
| 4. SOCIAL SECURITY NUMBER 235-24-0087 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 9, 1923 | |
| 8. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH --- | |
| 10a. STATE Maryland | | | | 10b. COUNTY --- | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3608 Lyndale Avenue | | 10f. ZIP CODE 21213 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: --- | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver | | | | 16b. KIND OF BUSINESS/INDUSTRY Local 557 Teamster | | 17. FATHER'S NAME (First, Middle, Last) John B. Morris | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Verletta O'Dell | | | | 19a. INFORMANT'S NAME (Type/Print) Dolores C. Morris (Wife) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3608 Lyndale Avenue, Baltimore, Md. 21213 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) --- | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home, Inc. 3331 Brehms Lane, Baltimore, Md. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metabolic Acidosis DUE TO (OR AS A CONSEQUENCE OF): b. Acute Renal Failure DUE TO (OR AS A CONSEQUENCE OF): c. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): d. Myocardial Infarction / RUL Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death 20 hrs. 48 hrs. 48 hrs. 72 hrs. | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. --- | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) --- | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) --- | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED --- | | | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) --- | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) --- | | | | 29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29a. SIGNATURE AND TITLE OF CERTIFIER M.D. | | | | 29b. LICENSE NUMBER 243-8946 F28 | | 29c. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ASAD, 201-E-UNIV PKWAY BALTO MD 21218 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DE WILGH BODMD

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00203 | |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | |
| JOHN H. WOMACK | | | | MONTH 1 / DAY 12 / YEAR 94 | | | | 6:45 A. M. | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | |
| 224-66-9585 | | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 48 YRS. | | 03-01-45 | | VIRGINIA | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | |
| CHURCH HOME HOSPITAL | | | | BALTIMORE | | | | n/a | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | |
| 10a. STATE | | 10b. COUNTY | | BALTIMORE | | | | <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| MARYLAND | | n/a | | | | | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | |
| 20 NORTH BROADWAY apt. 20 | | | | 21231 | | | | UNITED STATES | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| Elementary/Secondary (0-12) 6 TH | | College (1-4 or 5+) UNEMPLOYED | | n/a | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| JAMES WOMACK JR. | | | | ALICE LOVELACE | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| NADINE MANLEY | | | | 7508 MONTEVIDEO COURT, JESSUP, MARYLAND 20794 | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | MT. ZION CEMETERY | | 01-08 | | LANSDOWNE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | |
| | | | | X WM.C. MARCH FH.- 1101 E. NORTH AVENUE | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anoxic Encephalopathy | | | | | | | | 4 days | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? | |
| Diabetes Mellitus | | | | | | | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| Renal Failure | | | | | | | | | |
| Cardiomyopathy | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| | | | | | | | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| | | | | | | D44 378 | | 1/2/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| MANSON MATHIAS MD. 2406 VILLAGE DRIVE ARLING HEIGHTS MD 20701 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | |
| JAN 07 1994 | | | | | | | | | |

20500 42

REVENUE BOARD

SECRETARY

REVENUE BOARD

SECRETARY

SECRETARY

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00204

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) AMOS E. NEWKIRK | | | | 2. DATE OF DEATH MONTH 01 DAY 02 YEAR 1994 | | 3. TIME OF DEATH 10 48 A M | |
| 4. SOCIAL SECURITY NUMBER 239- 46-0394 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 60 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-17-33 | |
| 9a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTO | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5012 DENMORE AVE | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 6+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY SUBUBAN CLUB | |
| 17. FATHER'S NAME (First, Middle, Last) MACK D. NEWKIRK | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ALDERMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) JULIA JONES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 REISTERTOWN RD BALTO, MD 21215 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial park | | DATE 1/7/94 | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John March</i> | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H WEST 4300 WABASH AVE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC CANCER Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PRIMARY UNKOWN DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, mild renal insufficiency. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29c. DATE SIGNED (Month, Day, Year) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Madhu Jain MD</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MADHU JAIN MD PGYIII SINAI HOSPITAL BALTIMORE MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Sanders-Russell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and conscientiously filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17307 13

AD 1940 11/1/40

Mr. James E. Smith

(7)

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00205

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BOBBIE NEWTON | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 1 1994 | | 3. TIME OF DEATH 2:18PM | |
| 4. SOCIAL SECURITY NUMBER 216-42-9899 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 48 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6-9-45 | |
| 9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH N/A | |
| 10a. STATE MD | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 1843 N. CHESTER STREET | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED | | 16b. KIND OF BUSINESS/INDUSTRY N/A | |
| 17. FATHER'S NAME (First, Middle, Last) SIDNEY D. NEWTON, SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE BLACK | | | |
| 19a. INFORMANT'S NAME (Type/Print) CATHERINE BLACK | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1843 N. CHESTER STREET/BALTIMORE, MD 21213 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY | | 20c. LOCATION — City or Town, State CATONSVILLE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Embolism DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death 24 hr 24 hr | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure, Substance Abuse | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER MD050 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven M. [illegible] MD Johns Hopkins Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that an official certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00206

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last) Walter. OUTLAW | | | | 2. DATE OF DEATH MONTH DAY YEAR 01.02.1994 | | 3. TIME OF DEATH 11.15 a.m. | |
| 4. SOCIAL SECURITY NUMBER 231-09-7809 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-22-02 | |
| 9a. FACILITY NAME (If not institution, give street and number) HOWARD COUNTY GENERAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH JESSUP | | 9c. COUNTY OF DEATH HOWARD | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY HOWARD | | 10c. CITY, TOWN OR LOCATION JESSUP | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8921 CARROLL HEIGHTS AVE | | | | 10f. ZIP CODE 20794 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MERCHANT SEAMAN | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print) ETHEL MAE OUTLAW | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8921 CARROLL HEIGHTS AVE JESSUP, MD 20794 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) MEADOWRIDGE CEMETERY 1794 | | 20c. LOCATION — City or Town, State ELKRIDGE, MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladys Warner | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H- WEST 4300 WABASH AVE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Due to (or as a consequence of): a. BRONCHO PNEUMONIA Due to (or as a consequence of): b. RENAL FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA OF LARYNX ATHEROSCLEROTIC CARDIO VASCULAR DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER N. B. Vellanki, MD | | 29c. LICENSE NUMBER D30469. | | 29d. DATE SIGNED (Month, Day, Year) 01.02.1994. | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9055, Chevrolet Drive, #Suite 100, Ellicott City, MD 21042. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | 32. REGISTRAR'S SIGNATURE Julia Benson-Russell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00800 9

94-0035-510

ASP ITEM: 4. PER F.H. FILM G-707 1/25/94 t.t

Item 20b F.H. Film# G-707 01/7/94 R.M.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00207

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WALTER LYNN OLIVER | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 02 1994 | | 3. TIME OF DEATH 2125 P M | |
| 4. SOCIAL SECURITY NUMBER 231-31-2383 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 24 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-31-69 | |
| 8. BIRTHPLACE (State or Foreign Country) NEW YORK | | 9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH n/a | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 307 E. 23 RD STREET | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last) JIMMY SMITH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GERALDINE OLIVER | | | |
| 19a. INFORMANT'S NAME (Type/Print) GERALDINE JONES | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1372 HALSTEAD ROAD, BALTIMORE, MARYLAND 21234 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of place) ALBRIGHT CHURCH CEMETERY | | DATE | | 20c. LOCATION — City or Town, State AMELIA CO., VIRGINIA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Gunshot Wounds DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> MOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> _____ 4 <input checked="" type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 01-02-1994 | | 28b. TIME OF INJURY 9:16 P M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT WAS SHOT | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) STREET | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1900BLK GREENMOUNT AVE | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) 01-03-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODOR M. KING 111 Penn Street, Baltimore, Maryland 2 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00208

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Michael K. Oxendine Oxendine | | | | 2. DATE OF DEATH MONTH January DAY 4, 1994 YEAR | | 3. TIME OF DEATH 1:11 am M | |
| 4. SOCIAL SECURITY NUMBER 217-88-5603 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 34 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 12, 1959 | |
| 8. BIRTHPLACE (State or Foreign Country) Italy | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | |
| 9c. COUNTY OF DEATH Baltimore County | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Middle River | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 7354 Chesapeake Road | |
| 10f. ZIP CODE 21220 | | | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sanitation | | 16b. KIND OF BUSINESS/INDUSTRY Baking Company | |
| 17. FATHER'S NAME (First, Middle, Last) Earl Oxendine | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mayme Young | | | |
| 19a. INFORMANT'S NAME (Type/Print) Virginia Oxendine | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7354 Chesapeake Road Middle River, Maryland 21220 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Mem. Gard. 1/6/94 | | 20c. LOCATION — City or Town, State Baltimore County, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home PA 1407 Eastern Avenue Essex, Maryland 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Disseminated Intravascular Coagulopathy DUE TO (OR AS A CONSEQUENCE OF): b. Autoimmune Hemolytic Anemia DUE TO (OR AS A CONSEQUENCE OF): c. History of Wiskott Aldrich Syndrome DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Forman | | | |
| 29c. LICENSE NUMBER D-1732 | | | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeff Forman M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30509 42

RECEIVED

APR 19 1964

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JESSIE J. REIVES | | | | 2. DATE OF DEATH MONTH 01 DAY 02 YEAR 1994 | | | | 3. TIME OF DEATH 1250 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-26-0545 | | | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-20-1930 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE MD. | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1047 BETHUNE ROAD | | | | | | 10f. ZIP CODE 21225 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LAUNDRY WORKER | | | | 16b. KIND OF BUSINESS/INDUSTRY FORT MEADE | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) CLARENCE PAILOTT | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH E. BROOKS | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) HOWARD REIVES | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1047 BETHUNE ROAD, BALTIMORE, MARYLAND 21225 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| b. metastatic endometrial cancer | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| c. | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | |
| Approximate Interval Between Onset and Death 5 min | | | | | | | | | | | | | |
| Approximate Interval Between Onset and Death 4 months | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension, congestive heart failure, diabetes mellitus | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Mani Black D.D. | | | | 29c. LICENSE NUMBER D 31468 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARI BLACKBURN, D.D., UMMS, 22 South Greene St, BALTO, MD 21201 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 0 6 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The attending physician is to complete this certificate and file it with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00210 | |
|---|--|--|--|--|---|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) EUGENE RICHARDSON | | | | 2. DATE OF DEATH MONTH January DAY 5 YEAR 1994 | | 3. TIME OF DEATH 1:50 P | | | |
| 4. SOCIAL SECURITY NUMBER 216-72-4440 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 34 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 9-16-59 | 8. BIRTHPLACE (State or Foreign Country) BALTO. MD. | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 111 WEST CENTRE STREET | | | | 10f. ZIP CODE 21201 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify | | 14. RACE — American Indian, Black, White, etc. BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNKNOWN | | 16b. KIND OF BUSINESS/INDUSTRY NURSES AID | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) EUGENE RICHARDSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JOYCE WILLIAMS | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) JOYCE SMITH | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 KORADA COURT APT. 2A | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) MOUNT ZION CEMETERY | | DATE 1-8 | | 20c. LOCATION — City or Town, State 3900 HOLLINS FERRY | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY IRVIN CARROLL 1712 WEST NORTH AVE | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiopulmonary arrest | | | | | | | | Approximate Interval Between Onset and Death Immediate | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiopulmonary arrest DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 6 month | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. severe severe cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  R. Menor, M.D. | | 29c. LICENSE NUMBER 43636 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. Menor, M.D. c/o Maryland General Hospital | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | |

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ERIC H. BLOOM

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94 00211

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HENRY W. SORRELL, Sr | | | | 2. DATE OF DEATH MONTH 1 DAY 5 YEAR 1994 | | 3. TIME OF DEATH 1:25 PM | |
| 4. SOCIAL SECURITY NUMBER 721-10-4920 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/27/12 | |
| 9a. FACILITY NAME (If not institution, give street and number) Augustine Lutheran N. H. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE MD | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3016 ST LUKE LANE | | 10f. ZIP CODE 21207 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 yrs College (1-4 or 5+) Pastor | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pastor | | | |
| 16b. KIND OF BUSINESS/INDUSTRY | | | | 17. FATHER'S NAME (First, Middle, Last) William Sorrell, Sr | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Lazard | | | | 19a. INFORMANT'S NAME (Type/Print) Ruby D. Sorrell | | | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3016 St Luke Lane Balto, Md 21207 | | | | 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cem 11/19/94 Balto, Md | | | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sala March | | | | 22. NAME AND ADDRESS OF FACILITY March F.H. West 4300 Wabash Ave | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Thrombosis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Harold Bob MD | | | | 29c. LICENSE NUMBER D15872 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HAROLD BOB MD 7220 Park Heights Ave 21208 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE John Benson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the hospital or attending physician within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00212

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Joe Stratford</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>01 01 94</i> | | 3. TIME OF DEATH <i>2125</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>247-16-3342</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>80</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>6-3-13</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>UNIVERSITY HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE CITY</i> | | 9c. COUNTY OF DEATH | |
| 10a. STATE <i>MD.</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>BALTIMORE CITY</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>3901 YOLANDA ROAD</i> | | | | 10f. ZIP CODE <i>21218</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>UNKNOWN</i> College (1-4 or 5+) <i>UNKNOWN</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>LABORER</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>LARRY HASKINS</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3901 YOLANDA ROAD BALTIMORE MD. 21218</i> | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MOUNT ZION CEMETERY</i> | | DATE <i>1-8</i> | | 20c. LOCATION — City or Town, State <i>3900 HOLLINS FERRY RD.</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>1712 WEST NORTH AVENUE 21217 IRVIN CARROLL FUNERAL HOME</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>subarachnoid Hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Fall</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) <i>11/1/94</i> | | 28b. TIME OF INJURY <i>7:15 P M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED <i>Fall down stairs.</i> | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Home</i> | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>SAME AS # 10</i> | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>11/1/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>22 S. Greene St. Baltimore 20707</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 07 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked for item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00213

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) DONALD EMERSON SHAY SR. | | | | 2. DATE OF DEATH JANUARY 6, 1994 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 207-03-1525 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 23, 1913 | |
| 8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA | | | | 9a. FACILITY NAME (If not institution, give street and number) 205 HILLTOP ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH LINTHICUM | |
| 9c. COUNTY OF DEATH ANNE ARUNDEL | | | | 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | |
| 10c. CITY, TOWN OR LOCATION LINTHICUM | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 205 HILLTOP ROAD | |
| 10f. ZIP CODE 21090 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PROFESSOR | | 16b. KIND OF BUSINESS/INDUSTRY DENTAL SCHOOL UNIVERSITY OF MARYLAND | |
| 17. FATHER'S NAME (First, Middle, Last) FREDERICK RAYMOND SHAY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) RACHAEL CLEMENTS HUGHES | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. SARA FRANCES SHAY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 HILLTOP ROAD, LINTHICUM, MARYLAND 21090 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK 01/09/1994 | | 20c. LOCATION — City or Town, State ELKRIDGE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. George Fisher</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pancreatic carcinoma with metastases</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary atherosclerotic heart disease</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael L Fisher MD</i> | | | | 29c. LICENSE NUMBER D15317 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL L FISHER MD 22 S. GREENE ST BALTIMORE, MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Benson Rudolph</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death within the Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| DECEDENT'S NAME (First, Middle, Last) | | | | | | DATE OF DEATH | | TIME OF DEATH | |
|---|--|--|-----------------------------|--|--|--|--|---|---|
| ALICE M. SAVERINO Alice Saverino | | | | | | MONTH 1 | DAY 3 | YEAR 94 | 01:26AM M |
| SOCIAL SECURITY NUMBER | | SEX | AGE (In yrs. last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | DATE OF BIRTH | |
| 216-32-2070 | | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 79 YRS. | MONTHS DAYS | | HOURS MIN. | | 5/20/14 | |
| FACILITY NAME (If not institution, give street and number) | | | | | | CITY, TOWN OR LOCATION OF DEATH | | | COUNTY OF DEATH |
| AGNES HOSPITAL ST. AGNES HOSPITAL | | | | | | BALTIMORE | | | NEW YORK, N.Y. |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| STATE | | COUNTY | | CITY, TOWN OR LOCATION | | | | INSIDE CITY LIMITS? | |
| MARYLAND | | BALTIMORE | | BALTIMORE | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| STREET AND NUMBER | | | | ZIP CODE | | | CITIZEN OF WHAT COUNTRY? | | |
| 417 WHEATON PLACE | | | | 21228 | | | U.S.A. | | |
| MARITAL STATUS | | WAS DECEDENT EVER IN U.S. ARMED FORCES? | | WAS DECEDENT OF HISPANIC ORIGIN? | | | RACE — American Indian, Black, White, etc. | | |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | Specify: WHITE | | |
| DECEDENT'S EDUCATION | | | | DECEDENT'S USUAL OCCUPATION | | | KIND OF BUSINESS/INDUSTRY | | |
| (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | | HOMEMAKING | | |
| 8TH GRADE | | | | | | | | | |
| FATHER'S NAME (First, Middle, Last) | | | | | | MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| ARTIBINO MARTINI | | | | | | ADA FABRI | | | |
| INFORMANT'S NAME (Type/Print) | | | | MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| EUGENE B. SAVERINO | | | | 4 MARTZ ROAD - SYKESVILLE, MD. 21784 | | | | | |
| METHOD OF DISPOSITION | | | | PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | LOCATION — City or Town, State | | |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | METRO CREMATORY 1/ BALTIMORE | | | | | |
| SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | NAME AND ADDRESS OF FACILITY | | | | | |
| | | | | HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE BALTIMORE, MD. 21229 | | | | | |
| PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cowdria Hart Disease</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICENSE NUMBER D33948 | | 29d. DATE SIGNED (Month, Day, Year) 1-3-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | |

Page 12



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00215

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Clarence Garfield Spence II</i> | | | | 2. DATE OF DEATH MONTH <i>01</i> DAY <i>02</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>1350</i> M | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>579-12-5752</i> | | 5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>83</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>05/29/10</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown, Md.</i> | | | 9c. COUNTY OF DEATH <i>Washington</i> | | | | |
| 10a. STATE <i>Md</i> | | | | 10b. COUNTY <i>Washington</i> | | 10c. CITY, TOWN OR LOCATION <i>Hagerstown</i> | | 10d. INSIDE CITY LIMITS? <i>1</i> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <i>20023 Jefferson Blvd</i> | | | | 10f. ZIP CODE <i>21742</i> | | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | | | |
| 11. MARITAL STATUS <i>2</i> <input checked="" type="checkbox"/> Married <i>4</i> <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 8+) <i>1 yr.</i> | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>engineer</i> | | | 15b. KIND OF BUSINESS/INDUSTRY <i>Railroad</i> | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Clarence Garfield Spence Sr.</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Hattie Mae Ickes</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Stella L. Spence</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>20023 Jefferson Blvd Hagerstown Md</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION <i>1</i> <input checked="" type="checkbox"/> Burial <i>2</i> <input type="checkbox"/> Cremation <i>3</i> <input type="checkbox"/> Removal from State <i>4</i> <input type="checkbox"/> Donation <i>5</i> <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>DATE</i> | | 20c. LOCATION (City or Town, State) <i>DATE</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>State Anatomy Board 655 W. Baltimore St, Balto, MD 21201</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sudden cardiac death</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Congestive heart failure</i> | | | | | | | | Approximate Interval Between Onset and Death <i>8 months</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>History Cardiac arrhythmia</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1</i> <input type="checkbox"/> Inpatient <i>2</i> <input checked="" type="checkbox"/> Outpatient <i>3</i> <input type="checkbox"/> DOA OTHER: <i>4</i> <input type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation <i>2</i> <input type="checkbox"/> Accident <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide <i>6</i> <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <i>1</i> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ra P. Pursh</i> | | | | 29c. LICENSE NUMBER <i>D32857</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/2/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Gary L. P. Pursh</i> | | | | <i>354 Mill St Hagerstown 21742</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 7 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i> | | | | | | | |

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5

Collection of the University of California, Berkeley

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00216

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) maurice Thornton | | | | 2. DATE OF DEATH MONTH 01 DAY 02 YEAR 94 | | 3. TIME OF DEATH 1820 M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 219-28-1435 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 60 61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 01-02-33 | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Balto | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 1637 Moreland Ave | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unknown | | 16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Rufus Thornton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosetta Cager | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Emma Thornton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1637 Moreland Ave Balto, Md 21216 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet 1/11/94 | | 20c. LOCATION — City or Town, State Owings Mills, Md | | DATE | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sala March | | | | 22. NAME AND ADDRESS OF FACILITY March A. H. - west 4300 Wabash Ave | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. hepatic encephalopathy b. hepatocellular carcinoma c. cirrhosis - hepatitis B + C d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Medical Intern | | 29c. LICENSE NUMBER NA. | | 29d. DATE SIGNED (Month, Day, Year) 1/12/94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Szellach Mercy Medical Center Baltimore MD 21202 | | 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | 32. REGISTRAR'S SIGNATURE John Senier-Randall | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07 00510

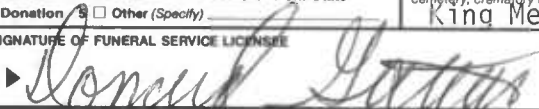


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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00217

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Mattie Bell Turner | | | | 2. DATE OF DEATH MONTH 1 DAY 3 YEAR 1994 | | 3. TIME OF DEATH n/a M | |
| 4. SOCIAL SECURITY NUMBER 242-24-5350 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-22-21 | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5526 Midwood Avenue | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? U S A | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (14 or 5+) N/A | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC | | 18b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) Blake | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bell Strowman | | | |
| 19a. INFORMANT'S NAME (Type/Print) George Turner | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 853 Bradhurst Road Baltimore, Md 21212 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park 1794 | | 20c. LOCATION — City or Town, State Randallstown, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FUNERAL HOME March F/H 1101 E. North Avenue | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. CARDIAC DYSRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): c. ARTERIO-SCLEROTIC C-V DYS DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. DESCRIBE HOW INJURY OCCURED | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  MD | | | | 29c. LICENSE NUMBER D00576 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been properly completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows injury, or other traumatic event, the medical examiner must be notified at once.

711-3 2

94-0102-510

blh ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-707 1/25/94 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00218

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Darrin E. Taylor | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 06 1994 | | 3. TIME OF DEATH M 0532 | |
| 4. SOCIAL SECURITY NUMBER 214-96-7481 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 28 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 05-24-65 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore CITY | |
| 9c. COUNTY OF DEATH NONE | | | | 10a. STATE MARYLAND | | 10b. COUNTY NONE | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 827 N. KENWOOD AVENUE | |
| 10f. ZIP CODE 21205 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: AFRICAN AMERICAN | | 14. RACE — American Indian, Black, White, etc. Specify: AFRICAN AMERICAN | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade College (1-4 or 5+) none | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER | | 16b. KIND OF BUSINESS/INDUSTRY BAUER TRUCKING CO. | |
| 17. FATHER'S NAME (First, Middle, Last) BENJAMIN TAYLOR JR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JEAN DAVIS | | | |
| 19a. INFORMANT'S NAME (Type/Print) BENJAMIN TAYLOR, JR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 N. KENWOOD AVE. BALTO, MD. 21205 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY 1/12/94 | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. NARCOTIC AND COCAINE INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) 1-6-94 | | 28b. TIME OF INJURY UNKNOWN | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | | |
| 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) FOUND IN HOUSE | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2715 E. PRESTON ST. BALTIMORE, MARYLAND | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Margarita A. Korell MD</i> | | | | 29c. LICENSE NUMBER O C M E | | 29d. DATE SIGNED (Month, Day, Year) 01 06 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita A. Korell, MD, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00219

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HELEN WILLIAMS E. | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 4 1994 | | 3. TIME OF DEATH 09:21 AM | |
| 4. SOCIAL SECURITY NUMBER 214-40 4991 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-5-10 | |
| 8. FACILITY NAME (If not Institution, give street and number) JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE Md | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION BALTO | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 607 N. Belmond Ave 21205 | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Secondary | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian | | 16b. KIND OF BUSINESS/INDUSTRY Balt School System | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Wesley Chester | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Johnson | | | |
| 19a. INFORMANT'S NAME (Type/Print) FLORENCE Rice | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5711 Mountain Rd Balto. Md 21266 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Arbutus mem PK. 1/8 | | 20c. LOCATION — City or Town, State Arbutus Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph B. Locks Jr | | | | 22. NAME AND ADDRESS OF FACILITY Locks Funeral Home 1304 N. Central | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Klebsiella pneumonia DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. Klebsiella urinary tract infection DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER John H. Hurd, MD | | 29c. LICENSE NUMBER J5785 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N. Wolfe St Balto, Md 21287 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | 32. REGISTRAR'S SIGNATURE John Sanders Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR


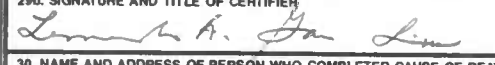

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21500 49

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Laura Wilhelm Laura M. Wilhelm | | | | | 2. DATE OF DEATH MONTH January DAY 1 , YEAR 1994 | | 3. TIME OF DEATH 8:11 A |
| 4. SOCIAL SECURITY NUMBER 216-03-3681 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 96 YRS. | 7. DATE OF BIRTH (Month, Day, Year) Oct. 21, 1897 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH ----- | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY ----- | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 301 McMechen Street | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/a College (1-4 or 5+) N/A | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Kitchen Worker | | 15b. KIND OF BUSINESS/INDUSTRY Lord Baltimore Hotel | | | |
| 17. FATHER'S NAME (First, Middle, Last) Howard Wilhelm | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Sterner | | | |
| 19a. INFORMANT'S NAME (Type/Print) Helen E. Morris (Daughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7752 Wynbrook Road, Baltimore, Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 1/5 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | 20d. DATE ----- | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gastro-Intestinal Bleeding Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="margin-left: 200px;"> a. Ischemic Bowel DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. </div> | | | | | | | Approximate Interval Between Onset and Death 24 Hours |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Distal Esophagitis with Ulcer Diverticulitis distal Colitis | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type, Print) Leonardo Ganlim M.D. C/O Maryland General Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00221

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|-------------------------------------|---|--|---|--|-------------------------------|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Albert Eugene Wolfe | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 5, 1994 | | 3. TIME OF DEATH M | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 282-16-2264 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 22, 1920 | | 8. BIRTHPLACE (State or Foreign Country) Ohio | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | | | 9c. COUNTY OF DEATH Anne Arundel | | | | | | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION Odenton | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Anne Arundel | | 10f. ZIP CODE 21113 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 10e. STREET AND NUMBER 1208 Howe Court | | | | | | | | | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Vice President | | 16b. KIND OF BUSINESS/INDUSTRY Carolina Biological Sup. | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Ross Wolfe | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ina McFadden | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sophia P. Wolfe | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 Howe Court, Odenton, MD 21113 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cem. | | DATE | | 20c. LOCATION — City or Town, State Arlington, VA | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas A. Hardesty | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridely Ave. Annapolis, MD 21401 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Arrest COPD Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Donald L. Alexander | | 29c. LICENSE NUMBER D14653 | | 29d. DATE SIGNED (Month, Day, Year) 1-7-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) 11 1300 Rte Hwy Annapolis MD 21012 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Swiden-Randall | | | | | | | | | | | |

13867

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00222

| | | | | | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Wan Hung Yip | | | | 2. DATE OF DEATH January 5, 1994 | | 3. TIME OF DEATH 1:00am | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 120-48-5103 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 86 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 11 23 07 | | 8. BIRTHPLACE (State or Foreign Country) CHINA | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH - | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY - | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 1609 W. NORTH AVENUE | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: ORIENTAL | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 08 College (1-4 or 5+) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY HOMEMAKER | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAE HUNG | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) SHEE LUN YIP | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1609 W. NORTH AVENUE-BALTIMORE, MD. 21217 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN CEMETERY | | DATE 1/8 | | 20c. LOCATION — City or Town, State GLEN BURNIE, MD. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry L. Kaufman</i> | | | | 22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD. | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pulmonary edema</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO N/A | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mys Swei Chang</i> | | 29c. LICENSE NUMBER Hosp no 89204 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mys Chang, M.D. c/o Mayrland General Hospital | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia K. B. B. B.</i> | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

00000 40

DEATH RECORD

100-4-000

100-4-000

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00223

| | | | | | | | |
|---|--|---|---|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Patricia J. Amend | | | | 2. DATE OF DEATH MONTH DAY YEAR 1 - 2 - 94 | | 3. TIME OF DEATH 4:15 AM | |
| 4. SOCIAL SECURITY NUMBER 217-36-3590 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (in yrs. last birthday) 56 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 09/16/37 | |
| 9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY HARFORD | | 10c. CITY, TOWN OR LOCATION BELAIR | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 612 McPhail Road | | | | 10f. ZIP CODE 21014 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) 2 YRS. | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Counselor | | 15b. KIND OF BUSINESS/INDUSTRY FAUSTON GENERAL HOSPITAL | | | |
| 17. FATHER'S NAME (First, Middle, Last) ROY LIPTRAP | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LATHERINE MAITH | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HIGHVIEW MEMORIAL PARK 1994 | | 20c. LOCATION — City or Town, State FAUSTON, Maryland | | OATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY EVANS FUNERAL CHAPEL - BELAIR, P.A. 3 NEWPORT DRIVE FOREST HILL, MD. 21050 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Brain cancer - GLIOBLASTOMA DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death 10 mos. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R. Faulkner MD | | | | 29c. LICENSE NUMBER D25643 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kendall R. Faulkner, M.D., 2300 Dulaney Valley Road, Towson, Maryland 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25500 30

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94-0002-510

B.K.S

ITEM: 23 PART I, PER MEO FILM G-709 3/4/94 t.t

ITEMS: 23 PART I, 27, 28a, b, c, d, e, f PER MEO G-707 1/12/94 reb

94 00224

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DEXTER ALLEN | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 01 94 | | 3. TIME OF DEATH 6:30 A M | |
| 4. SOCIAL SECURITY NUMBER 197-54-2970 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 32 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-4-61 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2700BLK. LAKEWOOD & PRESTON STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 226 N. Luzerne Ave | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed | | 18b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Stile Allen Jr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rebecca Taylor | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Velma Moseley | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1050 N. Milton Ave, Baltimore Md 21213 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. Zion Cem 1/8 | | 20c. LOCATION — City or Town, State BALTO. Co. Md. | | 20d. DATE 1/8 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | | 22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → NARCOTIC, ALCOHOL AND COCAINE INTOXICATION | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) REAR ALLEY LAKEWOOD & PRESTON ST | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) FOUND ON 1/1/94 | | 28b. TIME OF INJURY found at 6:20 | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND ON STREET | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) LAKEWOOD & PRESTON St. BALTIMORE, Md. | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Wayne Beckwith | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 01/01/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARYANN D. KOREL MO 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE Julia Anderson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

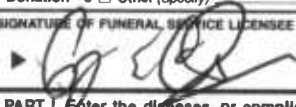
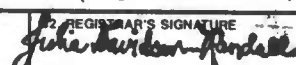
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 20 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00225

| | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) KATHERINE ANDERSON | | | | 2. DATE OF DEATH MONTH January DAY 07 YEAR 1994 | | | | 3. TIME OF DEATH 3:45 PM | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 705104814 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06/19/08 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION ROSEDALE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 6618 KENWOOD AVENUE | | | | 10f. ZIP CODE 21237 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) --- | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | | 16b. KIND OF BUSINESS/INDUSTRY HOUSEWIFE | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) VINCENT DONEGAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANCES YARNELL | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) PAUL M. ANDERSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6618 KENWOOD AVENUE BALTIMORE, MD 21237 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY | | DATE 1/10 | | 20c. LOCATION — City or Town, State TIMONIUM, MARYLAND | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | Approximate Interval Between Onset and Death 5 days | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal failure, Diabetes mellitus, high blood pressure | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER JOSE CASTRO, M.D. | | 29c. LICENSE NUMBER DEA 6048 | | 29d. DATE SIGNED (Month, Day, Year) 01/07/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSE CASTRO, 201 E. University Parkway, BALTIMORE, MD 21218 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | | | | | |

12-10-18

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | |
|--|--|--|--|---|---|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WENDY JOYCE ARNDT | | | | 2. DATE OF DEATH MONTH JANUARY DAY 3, 1994 YEAR | | 3. TIME OF DEATH 11:20 AM | | | | |
| 4. SOCIAL SECURITY NUMBER 220-72-3116 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCTOBER 10, 1957 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | |
| 9a. FACILITY NAME (If not institution, give street and number) 795 SOUTH OF ROUTE 140 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH REISTERSTOWN | | | 9c. COUNTY OF DEATH BALTIMORE | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY CARROLL | | 10c. CITY, TOWN OR LOCATION WESTMINSTER | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 367 N. COLONIAL AVENUE | | | | 10f. ZIP CODE 21157 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16 or 17+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | | 16b. KIND OF BUSINESS/INDUSTRY AT HOME | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES CLAYVILLE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARJORIE WOLFE | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) CHARLES CLAYVILLE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 367 N. COLONIAL AVE WESTMINSTER, MD 21157 | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OHEB SHALOM MEMORIAL PARK 1/6/94 | | 20c. LOCATION — City or Town, State REISTERSTOWN, MD | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Fullman</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>MI of System Trauma</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>None</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 1/3/94 | | 28b. TIME OF INJURY 11:20 AM | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED <i>Auto accident</i> | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>I-70 off rd 140 gmc</i> | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>290-2140</i> | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stacy Feldman Deputy Medical Examiner</i> | | | | | | 29c. LICENSE NUMBER D 01680 | | 29d. DATE SIGNED (Month, Day, Year) Jan 4, 1994 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Stacy Z. Feldman 11 E. Chase St 21201</i> | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00227 | | | |
|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | |
| Mary Anstine | | | | 1 5 94 | | | | 17:44 PM | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 217-48-9618 | | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 75 YRS. | | Feb. 22, 1918 | | England | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| Northwest Hospital Center | | | | Randallstown | | | | Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | | | |
| Maryland | | Baltimore | | Pikesville | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | |
| 2 Brightside Avenue | | | | 21208 | | U.S.A. | | | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | | | |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| Elementary/Secondary (0-12) 12 Years | | College (1-4 or 5+) | | Cafeteria | | Balto. Co. School System | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| John Harrison | | | | Isabella Henderson | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| Mr. Earl Anstine | | | | #2 Brightside Avenue Pikesville, MD 21208 | | | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | MD Veterans Cemetery | | 1/8 | | Garrison Forest MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| Stephen M Jenkins | | | | Loring Byers Funeral Director, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | | |
| a. <u>cardiovascular shock</u> | | | | | | | | | | | |
| b. <u>Aspirin h. f.</u> | | | | | | | | | | | |
| c. <u>C</u> | | | | | | | | | | | |
| d. <u></u> | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| <u>H/O CARC, S/P APPENDECTOMY</u> | | | | | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH | | 28a. DATE OF INJURY | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | (Month, Day, Year) | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | Alicia Hirsch | | | | M43974 | | 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | |
| | | | | JAN 10 1994 | | | | John Harrison | | | |

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00228

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|---------------|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) KATHERINE WORTHINGTON ANDREW | | | | 2. DATE OF DEATH MONTH January DAY 7, YEAR 1994 | | 3. TIME OF DEATH 4:00 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-03-6660 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 16, 1915 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Dulaney - Towson Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | 9c. COUNTY OF DEATH Baltimore | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3915 Beech Ave. | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5 +) | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | 15b. KIND OF BUSINESS/INDUSTRY Own Home | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Rollo F. Anderson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bernice Sharretts | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) James B. Andrew | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 561, Brooklandville, MD 21022 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory | | | DATE: 1/10/94 | | 20c. LOCATION — City or Town, State Baltimore, MD | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic Cardio Renal Vascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Parkinsonism Syndrome</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D-08383 | | 29d. DATE SIGNED (Month, Day, Year) 1/8/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles E. O'Donnell MD - 408 Harford Rd. - Baltimore, MD 21210 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0217 12



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00229

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Burtis | | | | 2. DATE OF DEATH January 9 1994 | | | | 3. TIME OF DEATH 3:40 a m | | | | | |
| 4. SOCIAL SECURITY NUMBER 099 01 5012 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) Nov. 10, 1911 | | 8. BIRTHPLACE (State or Foreign Country) New York | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Forestville | | 10c. CITY, TOWN OR LOCATION | | | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3409 Baywood Drive | | | | | | 10f. ZIP CODE 21050 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Thomas Burtis | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Kelly | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Thomas J. Gran | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 Baywood Drive Forest Hill, MD 21050 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Cemetery 1994 | | | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | | | 22. NAME AND ADDRESS OF FACILITY Evan Funeral Chapel — Bel Air, P.A. 3 New Port Drive Forest Hill MD 21050 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septic shock DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| c. Terminal cancer with metastasis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David Ho | | | | | | 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) 1-9-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Ho, M.D. c/o Maryland General Hospital | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Pendall | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STAGE 100000

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00230 | | | |
|--|--|---|--|---|--|--|--|--|--|-----------------------------------|--|
| 1. DECEASED'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | |
| Allen Charles BUTLER | | | | MONTH JAN DAY 09 YEAR 1994 | | | | 06:12 P.M. | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 7. DATE OF BIRTH | |
| 218-18-0619 | | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 74 YRS. | | MONTHS DAYS | | HOURS MIN. | | June 1, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| University Hospital | | | | Baltimore | | | | MARYLAND | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | | | |
| 10a. STATE | | 10b. COUNTY | | PARKVILLE | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| Md | | Baltimore | | | | | | | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 9210 ORBITAN Rd. | | | | 21234 | | | | USA | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | | | |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married | | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | Specify: White | | | | | |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | IF YES, GIVE WAR OR DATES WWII | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | | | PAINTER | | | | Contractor | | | |
| 10 | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| LEONARD BUTLER | | | | Loretta Green | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| ANNA BUTLER | | | | 9210 Orbitan Rd. Balto. Md. 21234 | | | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | | Parkwood Cemetery | | 1/2/94 | | PARKVILLE, Md. | | | | | |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| Robert L. Graves | | | | EVANS CHAPEL OF MEMORIES | | | | 2800 Harford Rd. BALTO. Md. 21234 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate interval between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | 6 DAYS | | | |
| a. SEPSIS | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| b. CARDIOVASCULAR COLLAPSE | | | | | | | | 6 DAYS | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| c. PULMONARY FAILURE | | | | | | | | 6 DAYS | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| d. MEDIASTINITIS / RENAL FAILURE | | | | | | | | 11 DAYS / 6 DAYS | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? | | | |
| CORONARY ARTERY DISEASE | | | | | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| RENAL INSUFFICIENCY | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | | | | 26. PLACE OF DEATH (Check only one) | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | Month, Day, Year | | M | | + <input type="checkbox"/> YES - <input checked="" type="checkbox"/> NO | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | | | | | | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| Kenneth E. Saum | | | | | | M4176435AS2134 | | Jan 09 1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| K. Saum no 22 S. Greene St. Balto Md. 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |
| JAN 10 1994 | | | | John Davidson-Rodale | | | | | | | |

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345-200-5 345-3144

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Willie Edward Brown</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>6</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>15 55</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>244-48-2933</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) <i>60</i> YRS. | | 7. DATE OF BIRTH MONTH <i>04</i> DAY <i>13</i> YEAR <i>33</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>UNIVERSITY HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i> | | 9c. COUNTY OF DEATH <i>n/a</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY <i>n/a</i> | | 10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>1023 N. CENTRAL AVENUE</i> | | | | 10f. ZIP CODE <i>21202</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>n/a</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>n/a</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>JAMES KELTY REALTY CO.</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>JOHNNY BROWN</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ADELL BROWN</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>ADELIA G. BROWN</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1023 N. CENTRAL AVENUE, BALTIMORE, MARYLAND 21202</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>CEDAR HILL CEMETERY</i> | | DATE <i>01-11</i> | | 20c. LOCATION — City or Town, State <i>ANNE ARUNDEL CO., MARYLAND</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>WM. C. MARCH FH.- 1101 E. NORTH AVENUE</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death <i>8 months</i> |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. <i>Cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | <i>11</i> |
| | | c. <i>Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | <i>11</i> |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>N. Tebyanian MD</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>1/6/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>N. Tebyanian MD Univ. of MD Hospital Baltimore, MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00232

| | | | | | | | | | |
|--|--|--|--|--|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY BOULDIN | | | | 2. DATE OF DEATH MONTH Jan DAY 8 YEAR 1994 | | 3. TIME OF DEATH 6:00 pm | | | |
| 4. SOCIAL SECURITY NUMBER 220- 01- 3052 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04- 05 - 04 | | 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | |
| 9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland | | | 9c. COUNTY OF DEATH Baltimore | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1213 LIGHT STREET | | 10f. ZIP CODE 21230 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) n/a | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) n/a | | 16b. KIND OF BUSINESS/INDUSTRY n/a | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) CLARISSA OLIVER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1434 N. AISQUITTH STREET, BALTIMORE, MARYLAND 21202 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) ARBUTUS MEMORIAL GARDEN | | OATE | | 20c. LOCATION — City or Town, State ARBUTUS, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROTIC HEART DISEASE | | | | | | | | Approximate Interval Between Onset and Death 3 DAYS | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D 4154 | | 29d. DATE SIGNED (Month, Day, Year) January 8 1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH POLITO M.D. J.H.H. 600 N. WOLFE ST BALT. MD. 21287 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.
IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00233 | |
|--|--|---|--------------------------------|---|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | |
| JOSEPH E BOTHOFF, SR. | | | | JAN. 7, 1994 | | | | 2245 | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In yrs. last birthday) | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 219-10-4577 | | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 67 YRS. | January 9, 1926 | | Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | |
| Northwest Hospital Center | | | | Randallstown | | | | Baltimore | |
| 10a. STATE | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | |
| Maryland | | | | Baltimore | | Baltimore | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 2202 Krone Court | | | | 21207 | | U.S.A. | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | | | Computer Room Operator | | S.S.A. | | | |
| 8th Grade | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| William Bothoff | | | | Wilhelmina Wiedeck | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| Mrs. Mary W. Bothoff | | | | 2202 Krone Court Baltimore, MD 21207 | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | Baltimore National Cemetery 1/11/94 | | 1/11/94 | | Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | |
| | | | | Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | |
| e. RUPTURED ABDOMINAL AORTIC ANEURYSM | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| EMPHYSEMA | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined | | | | 01-07-94 | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | 29b. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| S. M. D. | | | | D29276 | | 01-07-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| Z. MOKO. MD. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD 21133 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | |
| JAN 10 1994 | | | | Julia Davidson-Randall | | | | | |

94 00234

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EARLY E BAILEY | | | | 2. DATE OF DEATH MONTH 36 DAY 07 YEAR 94 | | 3. TIME OF DEATH 3:45 A M | |
| 4. SOCIAL SECURITY NUMBER 2 39-07-3736 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 5, 1902 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9. FACILITY NAME (If not institution, give street and number) Deaton Specialty Hosp. + Home | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH BALTO MD | | | | 11. COUNTY OF DEATH N. Carolina | | | |
| 12. STATE N. Carolina | | 13. COUNTY Forsyth | | 14. CITY, TOWN OR LOCATION Winston-Salem | | 15. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 16. STREET AND NUMBER 1732 Thurmond St. | | | | 17. ZIP CODE 27105 | | 18. CITIZEN OF WHAT COUNTRY? USA | |
| 19. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 22. RACE — American Indian, Black, White, etc. Specify: Black | |
| 23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/> | | 24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Minister | | 25. KIND OF BUSINESS/INDUSTRY Church | | | |
| 26. FATHER'S NAME (First, Middle, Last) Oscar Bailey | | | | 27. MOTHER'S NAME (First, Middle, Maiden Surname) Martha McLean | | | |
| 28. INFORMANT'S NAME (Type/Print) Clara Bailey | | | | 29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1732 Thurmond St., Winston-Salem, NC 27105 | | | |
| 30. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Evergreen Cemetery | | 32. DATE 1/14 | | 33. LOCATION — City or Town, State Winston-Salem, NC | |
| 34. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 35. NAME AND ADDRESS OF FACILITY ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214 | | | |
| 36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE | | | | | | 37. Approximate interval between Onset and Death YES | |
| 38. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST HYPERTENSION | | | | | | 39. DUE TO (OR AS A CONSEQUENCE OF): YES | |
| 40. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROVASCULAR DISEASE, | | | | | | 41. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 42. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 43. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 44. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 45. 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| 46. 28a. DATE OF INJURY (Month, Day, Year) | | 47. 28b. TIME OF INJURY M | | 48. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 49. 28d. DESCRIBE HOW INJURY OCCURED | |
| 50. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 51. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 52. 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 53. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 54. 29c. LICENSE NUMBER D31136 | | 55. 29d. DATE SIGNED (Month, Day, Year) JAN 7, 1994 | |
| 56. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN C. WALLACE MD, 611 S. CHARLES ST., BALTIMORE MD 21230 | | | | | | | |
| 57. 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 58. 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00534

RECEIVED
JAN 10 1963

[Handwritten signature]

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JAN 10 1963

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00235

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Benice Ernest Brown | | | | 2. DATE OF DEATH MONTH 1 DAY 5 YEAR 94 | | 3. TIME OF DEATH 11:27 AM | |
| 4. SOCIAL SECURITY NUMBER 224-48-6279 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 8, 1904 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | 9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Frederick | |
| 9c. COUNTY OF DEATH Frederick | | | | 10a. STATE Virginia | | 10b. COUNTY Loudoun | |
| 10c. CITY, TOWN OR LOCATION Lovettsville | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 9 North Berlin Pike | |
| 10f. ZIP CODE 22080 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S. of A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Funeral Director | | 16b. KIND OF BUSINESS/INDUSTRY Funeral Industry | |
| 17. FATHER'S NAME (First, Middle, Last) John D. Brown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Seitz | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lucille Brown | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 192, Lovettsville, Virginia 22080 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Union Cemetery Jan. 8, 1994 | | 20c. LOCATION — City or Town, State Lovettsville, Va. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Brown Funeral Home P.O. Box 320 Lovettsville, Virginia 22080 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval between Onset and Death 4d |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pseudomonas pneumonia | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Kathleen W Stern MD | | | | 29c. LICENSE NUMBER D32073 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kathleen W Stern MD 610 Ninth Ave Brunswick Md 21716 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020. The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

W. M. [Signature]

[Signature]

94 00236

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Paul Lynn Burris, Jr.</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>4</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>7:00 P</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>None</i> | | 5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN. <i>4</i> | | 7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 31, 1993</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> |
| 9a. FACILITY NAME (If not institution, give street and number) <i>University Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH | |
| 10a. STATE <i>Md.</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? <i>1</i> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>2238 Wilkens Avenue</i> | | | | 10f. ZIP CODE <i>21223</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <i>1</i> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <i>3</i> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>white</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>0</i> Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Infant</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Paul L. Burris, Sr.</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Jamie M. Brendle</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Jamie M. Brendle</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2238 Wilkens Ave., Balto., Md. 21223</i> | | | |
| 20a. METHOD OF DISPOSITION <i>1</i> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <i>4</i> <input type="checkbox"/> Donation <i>5</i> <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Loudon Park Cemetery 1/08</i> | | 20c. LOCATION — City or Town, State <i>Baltimore</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Gary L. Kaufman Funeral Homes 5695 Main St., Elkridge, Md. 21227</i> | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Hypoplastic left heart syndrome</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death <i>4 days</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <i>1</i> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1</i> <input type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> OOA OTHER: <i>4</i> <input type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation <i>2</i> <input type="checkbox"/> Accident <i>6</i> <input type="checkbox"/> Could not be determined <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | |
| 28c. INJURY AT WORK? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <i>1</i> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marisa J. Werner, MD</i> | | | | 29c. LICENSE NUMBER <i>D44122</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1-4-94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Marisa J. Werner, Univ. of Md. Hosp., 22 S. Greene St., Baltimore, MD 21201</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00237

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT H COSTELLO | | | | 2. DATE OF DEATH MONTH 01 DAY 07 YEAR 1994 | | 3. TIME OF DEATH 5:15 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 219-01-1789 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) DEC 17, 1920 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) G. B. M.C. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | | 9c. COUNTY OF DEATH BALTIMORE | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION Timonium | | | |
| 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | 10e. STREET AND NUMBER 2119 SUBURBAN GREENS DRIVE | | 10f. ZIP CODE 21093 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES W-W-II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS College (1-4 or 5+) SALES MANAGER | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES MANAGER | | 16b. KIND OF BUSINESS/INDUSTRY ARMCO STEEL | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) WALTER S. COSTELLO | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARIE A. MCNEER | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNTAIN CEMETERY 1-10 | | DATE 1-10 | | 20c. LOCATION — City or Town, State BALTO. MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY EVANSCHAPLOFF CHINESE 2325 YORK ROAD - Timonium | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RESPIRATORY FAILURE a. DUE TO (OR AS A CONSEQUENCE OF): COPD b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death 1 wk 10 yrs | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes mellitus Osteoporosis | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 8 Nomicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER William E. Rumbel & Attorney | | | | 29c. LICENSE NUMBER DISKUX | | 29d. DATE SIGNED (Month, Day, Year) 1-7-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

94-0084-510

blh

94 00238

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Richard W. Cofield | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 05 1994 | | 3. TIME OF DEATH 0222 M | |
| 4. SOCIAL SECURITY NUMBER 219-40-9095 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 52 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-17-41 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Cntr. | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1255 Sunrise Beach Rd. | |
| 10f. ZIP CODE 21032 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life, not last unless retired) Steel worker | | 15b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Warren Cofield | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alma Franklin | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Anita Cofield | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1255 Sunrise Beach Rd. Crownsville Md. 21032 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cem. Co. Balto. Co. Md. | | 20c. LOCATION — City or Town, State Balto. Co. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | | | | 22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2202 W. North Ave. Balto. Md. 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Inquiry 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Jaron Locke MD | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01 05 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE John A. Anderson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00239 | |
|---|--|---|--------------------------------|--|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | |
| JOHN J. CONNELLY | | | | Jan 5 1994 | | | | 1:35 pm | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In yrs. last birthday) | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 214-05-3192 | | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 76 YRS. | JAN. 7 1917 | | BALTO. MD. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH | | | |
| Saint Joseph Hospital | | | | Towson, Maryland | | Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | |
| MARYLAND | | BALTIMORE CO. | | PARKVILLE | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 3052 OAK FOREST DRIVE | | | | 21234 | | U.S.A. | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American-Indian, Black, White, etc. | | | |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | Specify: WHITE | | | |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | IF YES, GIVE WAR OR DATES | | Specify: | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | | | TEXTILE BROKER | | SELF EMPLOYED | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| JOHN J. CONNELLY | | | | HELEN CONNELLY | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| MARY ELIZABETH CONNELLY | | | | SAME AS BOX 10E. | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | | DULANEY VALLEY MEM. 1-8-94 | | COCKEYSVILLE, MD. | | | | | |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | |
| Jeffrey S. Jain LIC.# 1700677 | | | | EVANS CHAPEL OF MEMORIES 3800 HARFORD RD PARKVILLE, MD | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE | | | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): ACUTE MYOCARDIAL INFARCTION | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) | | | | | |
| | | | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation | | | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 2 <input type="checkbox"/> Accident | | | | | | | | | |
| 3 <input type="checkbox"/> Suicide | | | | | | | | | |
| 4 <input type="checkbox"/> Homicide | | | | | | | | | |
| 6 <input type="checkbox"/> Could not be determined | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | Francis T. Khoo | | | | | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) | | | | | |
| D30263 | | | | 1-5-94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| FRANCIS T. KHOO, M.D. ST. JOSEPH HOSPITAL, 7620 YORK ROAD, TOWSON MD. 21204 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | |
| JAN 10 1994 | | | | John Davidson-Rodriguez | | | | | |

January 1951

1951-1952

1951-1952

1951

1951-1952

1951-1952

94 00240

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) EVA W. COOK | | | | 2. DATE OF DEATH MONTH 1 - DAY 4 - YEAR 94 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 219-14-8558 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7-8-1922 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) 2910 Allendale Road | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2910 Allendale Road | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Louis H. Williams | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CORA V. DAWSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Theresita Jackson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2910 Allendale Rd. Baltimore Md 21216 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cem | | 20c. LOCATION — City or Town, State 17 BALTO Co. Md | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | | 22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md 21216 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pancreatic Cancer 6 mon DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death 6 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Keith S. Or | | | | 29c. LICENSE NUMBER D24521 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/93 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE John Davidson-Rodell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate must be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-10-10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00241

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|--|--|--|--------------------------------|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HEE WAN CHOI | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN. 6 1994 | | 3. TIME OF DEATH P. M. 2:00 P. M. | | | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 62 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) JAN. 12, 1931 | | | | | |
| 8. BIRTHPLACE (State or Foreign Country) KOREA | | | | 9a. FACILITY NAME (If not institution, give street and number) 5230 CEDAR LANE APT. 129 | | 9b. CITY, TOWN OR LOCATION OF DEATH COLUMBIA | | | | | |
| 9c. COUNTY OF DEATH HOWARD | | | | 10a. STATE MARYLAND | | 10b. COUNTY HOWARD | | | | | |
| 10c. CITY, TOWN OR LOCATION COLUMBIA | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 5230 CEDAR LANE APT. 129 | | | | | |
| 10f. ZIP CODE 21044 | | | | 10g. CITIZEN OF WHAT COUNTRY? KOREA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: KOREAN | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PROFESSOR | | 16b. KIND OF BUSINESS/INDUSTRY GOVERNMENT EMPLOYEE KOREAN GOVERNMENT | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) SANG HO CHOI | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) PIL YONG KIM | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) DR. SONG CHOL CHON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5230 CEDAR LANE APT. 129 Columbia, MD. 21044 | | | | | | | |
| 20a. MANNER OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LAKEMONT MEMORIAL GARDEN 1/12/94 | | 20c. LOCATION — City or Town, State DAVIDSONVILLE, MD. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPHYXIAATION by Hanging b. Depression Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. diabetes mellitus d. | | | | | | | | Approximate interval Between Onset and Death m months | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D31473 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAULINE A. TORE, MD 4565 itenlocke coneway Bldg City MD 21042 | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

94 00242

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Clara Herbertine Clausen</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>6</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>1133</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>577-48-6583</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) <i>70</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>11/08/23</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>409 Porpoise Lane</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Riva</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Germany</i> | | | |
| RESIDENCE OF DECEDENT | | | | 9c. COUNTY OF DEATH <i>AA</i> | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Ann Arundel</i> | | 10c. CITY, TOWN OR LOCATION <i>Riva</i> | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>409 Porpoise Lane</i> | | | | 10f. ZIP CODE <i>21140</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>10</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Johann Peter Meutgens</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Anna Marie Kloters</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Linda Blanton</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1161 Bacon Ridge Rd. Crownsville, MD 21032</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arlington National</i> | | 20c. LOCATION — City or Town, State <i>11/3/94 Arlington, VA</i> | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David K...</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Cunningham Funeral Home P.O. Box 65 Alexandria, VA 22313</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Acute Cardiac Insufficiency</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Hypertensive Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William P. Jones, MD Deputy</i> | | | | 29c. LICENSE NUMBER <i>D00056</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/6/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>William P. Jones, MD 695 America 21035</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Fish...</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00243 | |
|---|--|---|---|---|---|
| CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. DECEASED'S NAME (First, Middle, Last) Louis Dayton Carrier | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH M |
| 4. SOCIAL SECURITY NUMBER 216-12-5913 | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 83 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 11/16/10 | 8. BIRTHPLACE (State or Foreign Country) Bristol, Tenn. | |
| 9a. FACILITY NAME (If not institution, give street and number) 1301 Delphi Ct. | | | 9b. CITY, TOWN OR LOCATION OF DEATH Bel Air | | 9c. COUNTY OF DEATH Harford |
| 10a. STATE Maryland | | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Bel Air |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 1301 Delphi Ct. | | | 10f. ZIP CODE 21014 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Crane Operator | | 16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel Corp. | |
| 17. FATHER'S NAME (First, Middle, Last) Alvia David Carrier | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sallie Louise Snyder | | |
| 19a. INFORMANT'S NAME (Type/Print) Alvia D. Carrier | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 Delphi Ct. Bel Air 21014 | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Mem. Cdns. 1/7/94 | | 20c. LOCATION — City or Town, State Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE E. F. Lassahn Funeral Home | | | 22. NAME AND ADDRESS OF FACILITY E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, md. 21087 | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pulmonary Edema. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. _____ DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | 28d. DESCRIBE HOW INJURY OCCURRED |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUMBER D44793 | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE | | | |

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--------------------------------|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) William W. Copeland | | | | 2. DATE OF DEATH MONTH 1 - DAY 6 - YEAR 1994 | | 3. TIME OF DEATH 11:00 A M | |
| 4. SOCIAL SECURITY NUMBER 227-14-6114 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 76 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 3-13-1917 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1942 Denbury Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Dundalk | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Dundalk | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1942 Denbury Road | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) High School | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pipe Inspector | | 16b. KIND OF BUSINESS/INDUSTRY Steel Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Drummond H. Copeland | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eunice Walker | | | |
| 19a. INFORMANT'S NAME (Type/Print) Virginia Copeland | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1942 Denbury Rd., Dundalk, Maryland 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 1-7-94 | | 20c. LOCATION — City or Town, State Balto., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins D00083 | | | | 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd. Balto., Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHF DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. CVA DUE TO (OR AS A CONSEQUENCE OF): c. HBP DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. N/A | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Anthony Harrell M.D. | | | | 29c. LICENSE NUMBER D34779 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Anthony Harrell 2112 Dundalk Ave. Dundalk, Md. 21222 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Edith Dunn | | | | 2. DATE OF DEATH MONTH 1 DAY 6 YEAR 94 | | 3. TIME OF DEATH 8:30 A M | |
| 4. SOCIAL SECURITY NUMBER 213-10-6729 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) oct 18, 1907 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) LEVINDALE HEBREW HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6615 EBERLE DR., APT. 212 | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary <input type="checkbox"/> Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY AT HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) BENJAMIN SCHERR | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN FRIEDMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS BETH POZANEK | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 OLD CROSSING DR BALTO MD 21208 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BNAI ISRAEL 1/7/94 | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Metastatic Lung Cancer to Brain DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Breast and Pancreatic Cancer | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c. LICENSE NUMBER D23767 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DERA S WERTHEIMER 2434 W. BELVEDERE AVE. BALTO. MD 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00246

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LEON DAVIS Leon J. Davis | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 1210A M | |
| 4. SOCIAL SECURITY NUMBER 218-22-4193 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH Month 2 Day 27 Year 1929 | |
| 8a. FACILITY NAME (If not institution, give street and number) NORTHWEST HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8305 LACEWOOD LANE | | | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) KOREAN <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRESIDENT | | 16b. KIND OF BUSINESS/INDUSTRY JUDY VENDING COMPANY | | | |
| 17. FATHER'S NAME (First, Middle, Last) THEODORE DAVIS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BELLE ROMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS VIVIAN DAVIS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8305 LACEWOOD LANE BALTIMORE, MD 21208 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) BETH TITLOH | | DATE 1-5-94 | | 20c. LOCATION — City or Town, State BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FUNERAL HOME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular accident pineal hemorrhage | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 140891 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sybil M. Ritz NWHE | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. 94 00247 | |
|---|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED'S NAME (First, Middle, Last) MARGARET H. B. DIEHL | | | | 2. DATE OF DEATH MONTH 1 DAY 5 YEAR 1994 | | 3. TIME OF DEATH 11:45A | |
| 4. SOCIAL SECURITY NUMBER 389-05-0525 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 21, 1913 | |
| 8. BIRTHPLACE (State or Foreign Country) Nebraska | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Middle River | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 124 Compass Rd. | | 10f. ZIP CODE 21220 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) 4 yrs. | |
| 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Teacher | | | | 16b. KIND OF BUSINESS/INDUSTRY Education | | | |
| 17. FATHER'S NAME (First, Middle, Last) Peter Badgeron | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rutherford D. Diehl | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Compass Rd. Baltimore, Md. 21220 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Memorial Park 1-9-94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lassahn Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Advanced Carcinoma head of Pancreas Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Cancer Cachexia b. Multiple abdominal metastasis c. d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>STAFF SURGEON D17005</i> | | | |
| 29c. LICENSE NUMBER D17005 | | | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GOPAL GURUSHAMY, MD. Franklin Square Hospital. | | | | 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | |
| 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Miranda A. Edwards</u> | | | | 2. DATE OF DEATH MONTH <u>1</u> DAY <u>6</u> YEAR <u>94</u> | | 3. TIME OF DEATH <u>12:31 P M</u> | | | | | |
| 4. SOCIAL SECURITY NUMBER <u>245-13-3194</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>30</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>6-14-1963</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>N.C.</u> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>University Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Balto</u> | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE <u>Md</u> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <u>Balto Co.</u> | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <u>3454 Vargas Circle</u> | | | | 10f. ZIP CODE <u>21244</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4 yrs</u> College (1-4 or 6+) <u>4 yrs</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Teacher</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>Balto City Public Schools</u> | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Randolph Sessoms</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Annie Mae Edwards</u> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Annie Mae Townsend</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4118 Wiggins Mills Rd Wilson, N.C. 27893</u> | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Hamilton Gardens</u> <u>1/1/94</u> | | 20c. LOCATION — City or Town, State <u>Wilson, N.C.</u> | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Shirley B. Scott</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>March F.H. West</u> <u>4300 Wabash Ave</u> | | | | | | | |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Intracranial Hemorrhage</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death <u>18 hours</u> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY <u>M</u> 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dr. U. Sessoms MD</u> <u>Neurosurgery Resident</u> | | 29c. LICENSE NUMBER <u>MMMS-6226</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>1/6/94</u> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>22 South Greene Street, Baltimore, MD 21201</u> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>1/6 JAN 10 1994</u> | | | | | 32. REGISTRAR'S SIGNATURE <u>John A. Riddle</u> | | | | | | |

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00249

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Patricia Fleischmann</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>5</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>8:32 PM</i> | | | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>220-365205</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>53</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>3-9-1940</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | | | 9c. COUNTY OF DEATH | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE <i>Md.</i> | | 10b. COUNTY <i>Baltimore</i> | | 10c. CITY, TOWN OR LOCATION <i>Dundalk</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER <i>2022 Holborn Rd.</i> | | | | 10f. ZIP CODE <i>21222</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12th</i> | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i> | | 15b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>James J. Whalen</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ruth Reightler</i> | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Robert A. Fleischmann</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2022 Holborn Rd. Baltimore, Md. 21222</i> | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest</i> | | 20c. LOCATION — City or Town, State <i>Baltimore, Md.</i> | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Colt Connelly</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Connelly Funeral Home of Dundalk</i> <i>7110 Sollers Pt. Rd. Baltimore 21222</i> | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Arrest</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Hypoxia</i> <i>Prob Pulm embolism</i> | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Muscular Dystrophy</i> <i>Diabetes mellitus</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>David Steven - Medical Resident</i> | | | | 29c. LICENSE NUMBER <i>D44192</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/5/94</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>David Steven Francis Scott Key Med Center</i> | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John L. ...</i> | | | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00250 | |
|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Eddie Fogg, Jr. | | | | 2. DATE OF DEATH MONTH 1 DAY 5 YEAR 1994 | | 3. TIME OF DEATH 1:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER 218-36-6960 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 54 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 12/29/1939 | | 8. BIRTHPLACE (State or Foreign Country) North Carolina | |
| 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE North Carolina | | 10b. COUNTY Henderson | | 10c. CITY, TOWN OR LOCATION Henderson | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1801 Willlow Lane | | | | 10f. ZIP CODE 27536 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Afro-American | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Truck Driver | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Eddie Fogg, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Mayo | | | |
| 19a. INFORMANT'S NAME (Type/Print) Percy Fogg | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 833 Field View Rd. Balto, MD. 21207 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rolling Cemetery | | DATE Franklin CO, N.C. | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ | | 22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave Balto, MD. 21216 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Liver Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Alcoholic Cirrhosis Bleeding Esophageal varices Renal Failure | | | | | | | |
| 24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John Villano MD | | | | 29c. LICENSE NUMBER L1418 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen A Villano Johns Hopkins Hospital Tower 110 600 N Wolfe St Baltimore MD 21205 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE John Henderson | | | | | |

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00251

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) GOLDENSHTEYN, YAKOV | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 5 1994 | | 3. TIME OF DEATH 830 A M | |
| 4. SOCIAL SECURITY NUMBER 219 35 2860 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) AUGUST 1, 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION REISTERSTOWN | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 109 BROOKEBURY DR., APT 1-C | | | | 10f. ZIP CODE 21136 | | 10g. CITIZEN OF WHAT COUNTRY? RUSSIA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) COLLEGE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TAILOR | | 16b. KIND OF BUSINESS/INDUSTRY GARMENT | | | |
| 17. FATHER'S NAME (First, Middle, Last) FALIK GOLDENSHTEYN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) NECHA REDENSKYA | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS MARINA SIDELNICKOV | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 114 BROOKEBURY DR. REISTERSTOWN, MD 21136 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON (CHIZUK AMUNO) 1/7/94 | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | 20d. DATE 1/7/94 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Numerous intracranial bleeds DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST metastatic cancer to the brain DUE TO (OR AS A CONSEQUENCE OF): unknown primary cancer DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death 9 days unknown unknown | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD PhD PGY-I | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) JANUARY 5 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LINNEA BOYEV MD PhD SINAI HOSPITAL OF BALTIMORE | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours and submitted to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Lora Ginsberg</i> | | | | 2. DATE OF DEATH MONTH <i>January</i> DAY <i>4</i> YEAR <i>1994</i> | | 3. TIME OF DEATH <i>2230</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>215-10-5265</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>83</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>2-9-1910</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>SINAI HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i> | | 9c. COUNTY OF DEATH <i>MD</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>MD</i> | | 10b. COUNTY <i>BALTIMORE</i> | | 10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i> | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>3700 SEVEN MILE LANE, APT. B-3</i> | | | | 10f. ZIP CODE <i>21208</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <i>XX</i> | | 14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>SALES LADY</i> | | 15b. KIND OF BUSINESS/INDUSTRY <i>HECHT'S DEPT. STORE</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>ABRAHAM KURLAND</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>SARAH BARKIN</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>MR. ALAN GINSBERG</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3700 SEVEN MILE LA, APT. B3; BALTO, MD 21208</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>TZEMECH SEDEK VE SHOMREI HADATH BALTIMORE, MD</i> | | 20c. LOCATION — City or Town, State <i>BALTIMORE, MD</i> | | 20d. DATE <i>1-5-1994</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Hillman</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD, BALTO, MD 21215</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Cerebrovascular Accident</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death <i>5 days</i> <i>8 days</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cardiopulmonary arrest following aspiration, Cerebrovascular Accident following cardiopulmonary arrest</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY <i>M</i> | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26d. DESCRIBE HOW INJURY OCCURED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Medical Intern</i> | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>1/4/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Sam Sencil DO, Sinai Hospital</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>John T. Rusk</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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END OF PAGE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00253

| | | | | | | | | | |
|---|--|--|--|--|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Robert W. Grundman | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 4 1994 | | 3. TIME OF DEATH 6:45 A M | | | |
| 4. SOCIAL SECURITY NUMBER 212-09-9349 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7/16/13 | | 8. BIRTHPLACE (State or Foreign Country) Baltimore, Md. | |
| 9a. FACILITY NAME (If not institution, give street and number) Easton Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Easton | | | 9c. COUNTY OF DEATH Talbot | | |
| 10a. STATE Maryland | | 10b. COUNTY Queen Anne | | 10c. CITY, TOWN OR LOCATION Grasonville | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER Rt. 2 Box 466 | | | | 10f. ZIP CODE 21638 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician | | | 16b. KIND OF BUSINESS/INDUSTRY Armco | | |
| 17. FATHER'S NAME (First, Middle, Last) Frederick Grundman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Schleberger | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert R. Grundman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3935 Main St. Grasonville, Md. 21638 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood | | DATE 1/8/94 | | 20c. LOCATION — City or Town, State Baltimore, md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lassahn Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. Dehydration DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death days days days | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia ASCVD Renal Insufficiency | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ann Webb M.D. | | | | 29c. LICENSE NUMBER D10966 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann Webb M.D. 607 Dutchmans Lane Easton, Md. 21601 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

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ITEMS: 23,27 PER MEO G-707 1/12/94 reb

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) VENCE E. GENTRY | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 04 94 | | 3. TIME OF DEATH 9:29 P.M. | |
| 4. SOCIAL SECURITY NUMBER 246-46-6588 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-4-1935 | |
| 8a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL | | | | 8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 8c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY -- -- -- -- | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5153 Darien Road | | | | 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Yrs | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver | | 15b. KIND OF BUSINESS/INDUSTRY Own Business | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ernest Gentry | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred McKim | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Haught | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4029 St. Monica Dr., Balto., Md. 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GreenMount Crematory 1-8-94 | | 20c. LOCATION — City or Town, State Balto., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins D00083 | | | | 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Baltimore, Md. 21222 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Mario F. Golle Jr. | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 1-7-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mario F. Golle Jr. M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE John Anderson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-0099-510

ASP ITEM: 23 PART I, PER MEO FILM G-713 7/27/94 t.t

ITEMS: 23 PART I, 27, PER MEO FILM G-708 2/10/94 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00255

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) NOVELLA HUGGINS | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 06 1994 | | 3. TIME OF DEATH 12:02 AM | |
| 4. SOCIAL SECURITY NUMBER 218-46-6329 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 44 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04-18-1947 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) 725 GEORGE ST. | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 725 George St. Apt 5M | | | | 10f. ZIP CODE 21201 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | 16b. KIND OF BUSINESS/INDUSTRY Laundry | | | |
| 17. FATHER'S NAME (First, Middle, Last) Pearl Huggins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Mills | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lolita D. Freeman | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4923 Westhills Rd Balto Md. 21229 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Mem Pk 1/11/94 Arbutus, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY Caple Funeral Service 5502 Winner Ave. Balto Md. 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPOPHYTHYROIDISM COMPLICATED BY FOCAL BRONCHOPNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) 01-06-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 2 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00256

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES A. HENDRICKS | | | | 2. DATE OF DEATH MONTH 1 DAY 6 YEAR 94 | | | | 3. TIME OF DEATH n/a M | | | |
| 4. SOCIAL SECURITY NUMBER 217-46-1124 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 45 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 10-11-48 | | 8. BIRTHPLACE (State or Foreign Country) VIRGINIA | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 4804 STRATHDALE ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH N/A | | | |
| 10a. STATE MD | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 4804 STRATHDALE ROAD | | | | 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CORRECTIONAL OFFICER | | | | 16b. KIND OF BUSINESS/INDUSTRY MD PENITENTIARY | | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES H. HENDRICKS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SALLIE RUSSELL | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) PHYLLIS HENDRICKS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4804 STRATHDALE ROAD/BALTIMORE, MD 21206 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | DATE | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVENUE | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → hepatic cancer Approximate interval Between Onset and Death 4m Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. alcoholism | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICENSE NUMBER D25783 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 220 W Cold Spring Lane 21210 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

94 00257

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) HARRY J. HEISE SR. | | | | 2. DATE OF DEATH MONTH January DAY 7 , 94 YEAR 94 | | 3. TIME OF DEATH 7:30 A. M | |
| 4. SOCIAL SECURITY NUMBER 213-03-0962 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 79 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 | 7. DATE OF BIRTH (Month, Day, Year) Sept. 13, 1914 | |
| 8. BIRTHPLACE (State or Foreign Country) Balto. Md. | | | | 9. COUNTY OF DEATH Carroll | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Blizzard Care Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Finksburg | | 9c. COUNTY OF DEATH Carroll | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY City | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 602 Dale Ave. | | | | 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Grade | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Steel Worker | | 15b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Harry A. Heise | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Carney | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Harry J. Heise Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2103 Old Westminster Road Westminster, Md. 21157 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Service | | DATE 1/7/94 | | 20c. LOCATION — City or Town, State Hampstead, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eline</i> | | | | 22. NAME AND ADDRESS OF FACILITY Eline Funeral Home Reisterstown, Md. 21136 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CVA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ASCVD c. Alzheimer's d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Middleton</i> | | | | 29c. LICENSE NUMBER D25443 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John W. Middleton M.D. 1130 Baltimore Blvd. Westminster, Md. 21157 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Middleton</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1957

1957

1 - FOR
STATE
REGISTRAR

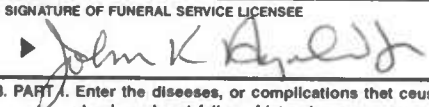


STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00258

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM R. HUGGINS, JR. | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 6, 1994 | | 3. TIME OF DEATH M M | |
| 4. SOCIAL SECURITY NUMBER 217-05-2260 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Nov 15, 1909 | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 9c. COUNTY OF DEATH Baltimore County | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore Co. | | 10c. CITY, TOWN OR LOCATION Randallstown | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 3801 Schnaper Dr. Apt. 436 | | | | 10f. ZIP CODE 21133 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR OATES WW 2 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Quality Control Clerk | | 16b. KIND OF BUSINESS/INDUSTRY Westinghouse | | | |
| 17. FATHER'S NAME (First, Middle, Last) William R. Huggins, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Franey | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Mary Lou Clare | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 Schnaper Dr. Apt 436 Randallstown, MD 21133 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Mem. Park 1-8-94 | | 20c. LOCATION — City or Town, State Sykesville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrhythmia Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): ASHD b. DUE TO (OR AS A CONSEQUENCE OF): Acute respiratory failure c. DUE TO (OR AS A CONSEQUENCE OF): COPD d. | | | | | | | Approximate interval Between Onset and Death 1 hr |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary bypass surgery | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER 216587 | | 29d. DATE SIGNED (Month, Day, Year) 1-7-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00259

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CARLTON RANSOM INSLEY, JR. | | | | 2. DATE OF DEATH MONTH Jan DAY 6 YEAR 1994 | | 3. TIME OF DEATH 4:15 am | |
| 4. SOCIAL SECURITY NUMBER 215-22-0297 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 66 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 21, 1927 | |
| 9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6002 Harford Rd. | | | | 10f. ZIP CODE 21214 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Broker | | 16b. KIND OF BUSINESS/INDUSTRY Real Estate | | | |
| 17. FATHER'S NAME (First, Middle, Last) Carlton R. Insley, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred Freda Ford | | | |
| 19a. INFORMANT'S NAME (Type/Print) Patricia Neuberger | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3132 Chesley Ave., Baltimore, MD 21234 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. John's Lutheran Ch. Cem. 1/8 | | DATE | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lymphoma CARCINOMA OF STOMACH IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death unknown | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Nicholas J. Belitsos M.D.</i> | | | | 29c. LICENSE NUMBER D18269 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NICHOLAS BELITSOS, M.D., 20 EAST EAGER STREET, BALTIMORE MD, 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

94 00260

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy M. Jackson</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>01-08-94</i> | | 3. TIME OF DEATH <i>4:50 am</i> M | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>215-05-0737</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) <i>85</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>03-16-08</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Baltimore, MD</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>295 Luther Drive</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Westminster</i> | | | | 9c. COUNTY OF DEATH <i>Carroll</i> | | | |
| 10a. STATE <i>MD</i> | | | | 10b. COUNTY <i>Carroll</i> | | 10c. CITY, TOWN OR LOCATION <i>Westminster</i> | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <i>295 Luther Drive</i> | | | | 10f. ZIP CODE <i>21157</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>white</i> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <i>4 year col.</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>William E. Churn</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Emma Russell</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mr. John R. Jackson</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>106 Nob Hill Dr. Reisterstown, MD 21136</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Lorraine Park Cemetery</i> | | 20c. LOCATION — City or Town, State <i>Baltimore, MD</i> | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James B. Eline</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Eline Funeral Home Reisterstown, MD 21136</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>PNEUMONIA</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CEREBROVASCULAR INSUFFICIENCY</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Harshley, MD</i> | | | | 29c. LICENSE NUMBER <i>D04934</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/9/94</i> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JOHN S. HARSHLEY MD 205 ST. MARK WAY WESTMINSTER, MD 21157</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i> | | | | | | | |



Item # 9a, 10e, 19b Film # G 1-13-94 N.A. Per. Funeral Home
ITEM: 4, per F.H. G-707 1/26/94 reb

94 00261

1 -
FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) HELEN S. KENT | | | | 2. DATE OF DEATH MONTH 01 DAY 6 YEAR 94 | | | | 3. TIME OF DEATH M | | | |
| 4. SOCIAL SECURITY NUMBER 410-32-2376 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 10 1923 | | 8. BIRTHPLACE (State or Foreign Country) MD. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 8 ROBERT AVE 8 Roberts Ave. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTO | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10a. STREET AND NUMBER 8 KENT AVE 8 Roberts Ave. | | | | 10f. ZIP CODE 21228 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) UYLESSESS SMITH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN WALLACE | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) JAMES KENT SR. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Roberts Ave. 8 ROBERT AVE BALTO, MD 21228 Baltimore, Md. 21228 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTO NATIONAL CEMETERY 11194 | | DATE BALTO, MD | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome A. Thompson Jr</i> | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H WEST 4300 WABASH AVE | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Metastatic Renal Cell Cancer (Metastatic to lung) DUE TO (OR AS A CONSEQUENCE OF): c. Do not resuscitate DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William K. Hirota</i> HIROTA | | | | | | 29c. LICENSE NUMBER MD D44085 | | 29d. DATE SIGNED (Month, Day, Year) 7 JAN 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 31. DATE FILER (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. Anderson</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature

ORIGINAL

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94 00262

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) IDA E. KERN | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN 08 / 1994 | | 3. TIME OF DEATH 2:03 PM | |
| 4. SOCIAL SECURITY NUMBER 213-10-5055 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-14-06 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) ST. ELIZABETH'S HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH MARYLAND | | | | 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | |
| 10c. CITY, TOWN OR LOCATION LINTHICUM | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 400 CATHERINE AVENUE | |
| 10f. ZIP CODE 21090 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECTION MANAGER | | | | 16b. KIND OF BUSINESS/INDUSTRY STORE STEWART'S DEPARTMENT | | | |
| 17. FATHER'S NAME (First, Middle, Last) ANDREW KERN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLEN BOWMAN | | | |
| 19a. INFORMANT'S NAME (Type/Print) EDWARD E. RIPLEY (FRIEND) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 CATHERINE AVENUE LINTHICUM, MARYLAND 21090 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOUNTAIN VIEW CEMETERY 01/11/94 | | | |
| 20c. LOCATION — City or Town, State UNION BRIDGE, MARYLAND | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | |
| 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Atrial Fibrillation DUE TO (OR AS A CONSEQUENCE OF): c. Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | |
| 29c. LICENSE NUMBER D30182 | | | | 29d. DATE SIGNED (Month, Day, Year) 1-10-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM RUSSELL MD 2320 BELSON AVE BALTIMORE 21227 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00263

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Thomas JR Kimmitt</i> THOMAS J. KIMMITT JR. | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>5</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>11:30 PM</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>212-01-5420</i> | | 5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>80</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>01-10-13</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>ST. AGNES HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i> | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY <i>BALTIMORE</i> | | 10c. CITY, TOWN OR LOCATION <i>ELKRIDGE</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <i>6550 HUNTSIRE DRIVE</i> | | | | 10f. ZIP CODE <i>21227</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>COMPTROLLER</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>W.R. GRACE</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>THOMAS J. KIMMITT</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>REGINA MEUSHAW</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>ANN LANSINGER (DAUGHTER)</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6550 HUNTSIRE ELKRIDGE MARYLAND 21227</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MEADOWRIDGE CEMETERY</i> | | DATE | | 20c. LOCATION — City or Town, State <i>DORSEY, MARYLAND</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Craig Witzke</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. End stage COPD</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>c. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>d.</i> | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wale Gamil 1st year Resident St. Agnes Hospital</i> | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>1/5/94</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | | | |

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William F. Keating | | | | 2. DATE OF DEATH MONTH Jan DAY 6 YEAR 94 | | 3. TIME OF DEATH 4 17 AM | |
| 4. SOCIAL SECURITY NUMBER 219 10 0568 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-27-25 | |
| 9a. FACILITY NAME (If not institution, give street and number) VETERANS ADMINISTRATION | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER 3117 Ferndale Ave | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 3 Widowed | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MEDIC U.S. ARMY MILITARY | | 16b. KIND OF BUSINESS/INDUSTRY MEDIC U.S. ARMY | |
| 17. FATHER'S NAME (First, Middle, Last) RICHARD J. KEATING | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET BELL | | | |
| 19a. INFORMANT'S NAME (Type/Print) SUSAN WHEAT (NIECE) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2423 CREIGHTON AVENUE BALTIMORE, MARYLAND 21234 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERANS CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | 20d. DATE OF DISPOSITION 01/11/94 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. chronic congestive heart failure | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Chronic obstructive pulmonary disease | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. recurrent pneumonia hypertension | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. recurrent pneumonia | | | | | | | |
| Approximate interval between Onset and Death | | | | | | | |
| 14 yrs. | | | | | | | |
| 14 yrs. | | | | | | | |
| 5 weeks. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| Hypothyroidism Laryngeal Cancer | | | | | | | |
| Non-Insulin Dependent Diabetes | | | | | | | |
| Reversible Liver Failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | 29c. DATE SIGNED (Month, Day, Year) | |
| 29d. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29e. SIGNATURE AND TITLE OF CERTIFIER Prashant Shukla MD | | | | | |
| 29f. LICENSE NUMBER MD 73-VAMC | | 29g. DATE SIGNED (Month, Day, Year) | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Prashant Shukla MD Dept. of Medicine VAMC-Baltimore MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1/6/94 JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

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TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

33207 40

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | |
|--|--|---|--|--|--|---|--|--|--|
| Otilia Josephine Kobunski | | | | January 6, 1994 | | | | M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | |
| 312-01-9272 | | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 80 YRS. | | June 17 1913 | | Indiana | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | |
| Meridian Long Green Center | | | | Baltimore City | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | |
| Maryland | | Carroll | | Westminister | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 3417 Pine Circle South | | | | 21157 | | United States | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | Specify: White | | | |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | IF YES, GIVE WAR OR DATES | | Specify: | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 15b. KIND OF BUSINESS/INDUSTRY | | | | | |
| Elementary/Secondary (0-12) | | College (1-4 or 5 +) | | Homemaker | | | | | |
| 9 | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| George McCarty | | | | Mary Ellen Sheets | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| Catherine Sue Morell | | | | 3417 Pine Circle South Westminister, Md. 21157 | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | | National Memorial Park | | 1/8/94 | | Falls Church Va. | | | |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | |
| Milton J. Knight Jr | | | | Baltimore, Md. 21214 | | | | | |
| Leonard J. Ruck, Inc. 5305 Harford Road | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure | | | | | | | | | |
| b. COPD | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| possible lung carcinoma | | | | | | | | | |
| Coronary artery disease | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH (Check only one) | | 24a. WAS AN AUTOPSY PERFORMED? | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 29a. CERTIFIER (Check only one) | | 29b. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | D28987 | | 1-7-94 | | | |
| 29d. SIGNATURE AND TITLE OF CERTIFIER | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | |
| Dr. Carl Sperling, M.D. | | | | 5601 Loch Raven Blvd. Baltimore, Md. | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | |
| JAN 10 1994 | | | | Julia Davidson-Randall | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00266 | | | | | |
|--|--|--|---|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Emily Ritter Kendall | | | | 2. DATE OF DEATH MONTH 01 DAY 07 YR 94 | | 3. TIME OF DEATH 9:45 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 217-16-5556 M | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 72 YRS. | 7. DATE OF BIRTH (Month, Day, Year) MAY 17, 1921 | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 2204 HAMILTON AVENUE | | | | 10f. ZIP CODE 21214 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK | | 16b. KIND OF BUSINESS/INDUSTRY U. S. GOVT. | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) FREDERICK RITTER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MINNA (UNKNOWN) | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) HARRY WALTER KENDALL | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 HAMILTON AVENUE BALTIMORE, MD. 21214 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OAK LAWN CEMETERY | | OATE 1/10/94 | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hank S. Zurek | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Inc. 5305 Harford RD Balto, MD. 21214 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): PNEUMONIA and Emyema b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MALNUTRITION pancreatitis | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARK MCGinley 9000 franklin SQ. DR. BALTO. MD. 21237 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Swickard | | | | | | | |

5-21-47
RECEIVED
FBI
JAN 21 1947

12

2

CLERK

U. S. DEPT. OF JUSTICE

FREDERICK

RITTER

MINNA

(UNKNOWN)

HARRY WALTER KENDALL

2204 HAMILTON AVENUE BALTIMORE, MD. 21214

X

OAK LAWN CEMETERY

1110 1/2 BALTIMORE, MD

6

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00267

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) GLADYS M. KIRSCH Gladys Mary Kirsch | | | | 2. DATE OF DEATH MONTH 1 DAY 9 YEAR 94 | | 3. TIME OF DEATH 9:15A M | |
| 4. SOCIAL SECURITY NUMBER 219-10-1763 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/31/00 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSP CORP 100 N BROADWAY | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO; MD 21231 | | 9c. COUNTY OF DEATH BALTO | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION BALTO; MD 21231 | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1046 Old North Point Road | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Clerk A&P | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk A&P | | 16b. KIND OF BUSINESS/INDUSTRY Food | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frederick Kirsch | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Costello | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edward Smetana | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13109 Manor Rd. Glen Arm, Maryland 21057 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park 1/11/94 | | DATE 1/11/94 | | 20c. LOCATION — City or Town, State Baltimore Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Milton J. Knight Jr | | | | 22. NAME AND ADDRESS OF FACILITY Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Road | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): ASCVD c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION / INTESTINAL OBSTRUCTION RELIEVED BY SURGERY 1/5/94 | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 1/11/94 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED NO INJURY | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER George A. Stumman MD | | | | 29c. LICENSE NUMBER D18977 | | 29d. DATE SIGNED (Month, Day, Year) 1/9/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GEORGE K. THOMAS / 100 N BROADWAY / BALTO MD 21231 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00268

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edna V. Keil | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 04 1994 | | 3. TIME OF DEATH 2:00 A. M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 217 01 2614 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04/29/1904 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Milford Manor Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH Baltimore County | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 4204 Old Milford Mill Road | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Abraham McKay | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Thomas Knott | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4869 Avoca Avenue Ellicott City, Maryland 21043 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. State Veterans Cem. | | DATE 1/7 | | 20c. LOCATION — City or Town, State Crownsville, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anna M. Zanisowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Due to (or as a consequence of):</i> <i>Dehydration</i> b. <i>Due to (or as a consequence of):</i> c. <i>Due to (or as a consequence of):</i> d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atherosclerosis</i> <i>Cardiomyopathy</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert K. Kroupnick</i> | | | | 29c. LICENSE NUMBER D14713 | | 29d. DATE SIGNED (Month, Day, Year) 7/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Kroupnick 8620 Liberty Plaza Mall Randallstown, Maryland 21133 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | | | |

2000-2001-2002-2003

94 00269

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Harry H. KASTER | | | | 2. DATE OF DEATH MONTH JAN DAY 1 YEAR 1994 | | 3. TIME OF DEATH 1:10 P.M. | |
| 4. SOCIAL SECURITY NUMBER 109-03-4154 | | 5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 25, 1912 | |
| 8. BIRTHPLACE (State or Foreign Country) Russia | | | | 9a. FACILITY NAME (If not institution, give street and number) 12001 Old Columbia Pike #514 | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | |
| 9c. COUNTY OF DEATH Montgomery | | | | 10a. STATE Maryland | | 10b. COUNTY Montgomery | |
| 10c. CITY, TOWN OR LOCATION Silver Spring | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 12001 Old Columbia Pike #514 | |
| 10f. ZIP CODE 20904 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4 or 5 +) | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner/Operator | | | | 16b. KIND OF BUSINESS/INDUSTRY Grocery | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Jacob Kosekevitz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose (Unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ruby Kaster | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12001 Old Columbia Pike #514, Silver Spring, MD 20904 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Judean Mem. Gardens Jan. 3, 1994 | | | |
| 20c. LOCATION — City or Town, State Olney, Maryland | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald C. Stottumyer | | | |
| 22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL ST., NW, WASHINGTON, DC 20012 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER John Tamber | | | |
| 29c. LICENSE NUMBER 8218 W. S. C. S. S. N. | | | | 29d. DATE SIGNED (Month, Day, Year) JAN 2 - 94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Tamber | | | | 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | |
| 32. REGISTRAR'S SIGNATURE Julia Davidson | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

27-3-1974

Page 10

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development since independence. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development since independence. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's economic development.

3. The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development since independence. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's social development.

4. The fourth part of the report deals with the political situation of the country. It is a very interesting and informative study of the country's political development since independence. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's political development.

94 00270

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles Kramer | | | | 2. DATE OF DEATH MONTH DAY YEAR January 3, 1994 | | | | 3. TIME OF DEATH 8:20 P. | | | | | |
| 4. SOCIAL SECURITY NUMBER 124-28-9212 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 11/24/36 | | 8. BIRTHPLACE (State or Foreign Country) Brooklyn, N.Y. | |
| 9a. FACILITY NAME (If not institution, give street and number) VA Medical Center, Baltimore | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 1114 E. Vanguard Way | | | | | | 10f. ZIP CODE 21015 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Real Estate Appraiser | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles P. Krammer Sr. | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marguerite Robertson | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Janice Ferguson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 427 Haslett Rd. Joppa, md. 21085 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 1/5/94 | | | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE E.F. Lassahn Funeral Home | | | | | | 22. NAME AND ADDRESS OF FACILITY E.F. Lassahn Funeral Home 11750 belair Rd. Kingsville, md. 21087 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | | | | |
| a. Multisystem organ failure DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| b. Aorta divided fistula DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| c. Aortic aneurysm DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO N/A | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER S. MARWAHA | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10 N. Greene St. Baltimore VA Hosp. 21201 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARGARET L KIDD | | | | 2. DATE OF DEATH MONTH 1 DAY 7 YEAR 94 | | 3. TIME OF DEATH 2:55 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-10-8208 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/27/18 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH BALTIMORE | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 2432 KEYWAY | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Dr. Office | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Paukner | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Baker | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert E. Clarke | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3485 Dunhaven Rd., Dundalk, Md. 21222 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park | | DATE 1/7/94 | | 20c. LOCATION — City or Town, State Baltimore, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins D00083 | | | | 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Baltimore, Md. 21222 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LIVER MALIGNANCY a. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STATUS POST LIVER BIOPSY ATRIAL FIBRILLATION HYPER TENSION, THROMBOCYTOPENIA | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 26. PLACE OF DEATH (Check only one) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Vasanthi Pui P | | | | 29c. LICENSE NUMBER HOWE STAFF | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VASANTHA YAI HARBOR HOSPITAL CENTER | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE Jodie Davidson-Randall | | | | | | | | | |

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17822 42



94 00272

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH LAZAR | | | | 2. DATE OF DEATH MONTH 01 DAY 09 YEAR 94 | | 3. TIME OF DEATH 4 P M | |
| 4. SOCIAL SECURITY NUMBER 214-38-9606 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03-01-36 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1120 WILSON AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE MARYLAND | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION CATONSVILLE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1120 WILSON AVENUE | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: HUNGARIAN | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TOOL & DIE MAKER | | 16b. KIND OF BUSINESS/INDUSTRY F & G TOOL & DIE | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARTA KOVACS | | | |
| 19a. INFORMANT'S NAME (Type/Print) GENEIVEVE JONES (FRIEND) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 WILSON AVENUE CATONSVILLE, MARYLAND 21207 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE, MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Chronic Alcoholism | | | | | | Approximate Interval Between Onset and Death YEARS | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D11171 | | 29d. DATE SIGNED (Month, Day, Year) 1/9/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. P. Williams 405 Frederick Ave Catonsville | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be completed and signed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 10



Page 10 of 10

94 00273

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) KAY LEVIN | | | | 2. DATE OF DEATH MONTH JANUARY DAY 6 , 1994 YEAR | | 3. TIME OF DEATH 12:30 AM | |
| 4. SOCIAL SECURITY NUMBER 218-46-1199 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MARCH 21, 1900 | |
| 8. BIRTHPLACE (State or Foreign Country) RUSSIA | | | | 9a. FACILITY NAME (If not institution, give street and number) NORTH OAKS HEALTH CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH PIKESVILLE | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | |
| 10c. CITY, TOWN OR LOCATION PIKESVILLE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 725 MT WILSON LANE, UNIT 225 | |
| 10f. ZIP CODE 21208 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOUSEWIFE | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | | |
| 16b. KIND OF BUSINESS/INDUSTRY AT HOME | | | | 17. FATHER'S NAME (First, Middle, Last) USHER BETTIGOLE | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE KELLAM | | | | 19a. INFORMANT'S NAME (Type/Print) MR NATHAN LEVIN | | | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 MT WILSON LANE, UNIT 225 BALTIMORE, MD 21208 | | | | 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ANSHE EMUNAH (AITZ CHAIM) 1-7-94 BALTIMORE, MD | | | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerry Allen Levin</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC OVARIAN CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 27. DATE OF INJURY (Month, Day, Year) | | | | 28a. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify) | | | |
| 28b. TIME OF INJURY | | | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael X. Levin</i> | | | | 29c. LICENSE NUMBER D06085 | | | |
| 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00274 | | | |
|--|--|--|--|---|--------------------------------|--|-------------------------------------|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) LUCY J. LOAR | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 07 94 | | 3. TIME OF DEATH 1405 | | M | | | |
| 4. SOCIAL SECURITY NUMBER 556 78 4003T | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 94 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 12-31-99 | | 8. BIRTHPLACE (State or Foreign Country) MD. VA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH ===== | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY ===== | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 22 S. Athol Avenue | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 1 <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th Grade College (13-16) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Home Maker | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Mason Hamman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hannah Combs | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Norma Bourke | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4011 - 3rd Street Baltimore, Maryland 21225 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Cedar Hill Cemetery | | DATE 1/10 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. Davis | | | | 22. NAME AND ADDRESS OF FACILITY George J. Gonc Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Benjamin S. Lee MD Medical Resident | | | | 29c. LICENSE NUMBER SBH-820 | | | | 29d. DATE SIGNED (Month, Day, Year) 1-7-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Benjamin S. Lee MD, St. Agnes Hospital, 900 Canon Ave, Baltimore, MD 21229 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE John A. ... | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00275

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mildred Catherine Lutsche | | | | 2. DATE OF DEATH MONTH 01 DAY 08 YEAR 1994 | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER 213 34 9146 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 55 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03/05/1938 | | 8. BIRTHPLACE (State or Foreign Country) Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 180 Falcon Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Pasadena | | | | 9c. COUNTY OF DEATH Anne Arundel | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Pasadena | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 180 Falcon Drive | | | | 10f. ZIP CODE 21122 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Home Maker | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jesse Curtis Pursley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Frances | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Linda Bookhamer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 180 Falcon Drive Pasadena, Maryland 21122 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 1/10 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George J. Gonc</i> | | | | 22. NAME AND ADDRESS OF FACILITY George J. Gonc Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Small cell cancer of lung</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death <i>1 yr</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. L. [Signature]</i> | | | | | | | | 29c. LICENSE NUMBER <i>D18587</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/10/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Paul Gormley 900 Caton Ave Balt, MD 21225</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | | | |

94 00276

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BECKIE LINDENBERG | | | | 2. DATE OF DEATH MONTH 01 DAY 05 YEAR 1994 | | 3. TIME OF DEATH 7:05 AM | |
| 4. SOCIAL SECURITY NUMBER 178 22 3950 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 98 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 25, 1895 | |
| 9a. FACILITY NAME (If not institution, give street and number) Randolph Hills Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH Wheaton, | | | | 9c. COUNTY OF DEATH Montgomery | |
| 10a. STATE Maryland | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 15100 Interlachen Blvd., | | | | 10f. ZIP CODE 20906 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Unknown | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager | | 16b. KIND OF BUSINESS/INDUSTRY Dress Factory | | | |
| 17. FATHER'S NAME (First, Middle, Last) Label Weiss | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rachel Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rae Wertlieb | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same address as #10 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Sharon Cemetery | | 20c. LOCATION — City or Town, State 1-7-94 Springfield, Pa. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church, Va. 22046 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 1 week |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's dementia Gastrointestinal hemorrhage | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeanne P. Asher MD</i> | | | | 29c. LICENSE NUMBER D34032 | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEANNE P. ASHER 3720 FARRAGUT AVE KENSINGTON MD 20895 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE <i>Johanna Anderson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00277

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DALE E. LUNDBERG | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 04 94 | | 3. TIME OF DEATH 1600 M | | | |
| 4. SOCIAL SECURITY NUMBER 218019755 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 04 02 21 | | 8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 700 DEVONSHIRE ROAD | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11TH GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY HOMEMAKING | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH L. DAVIS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANN APPLESTEIN | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) LORETTA ROBEY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 724 S. WOODINGTON RD. BALTO. MD 21229 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY | | DATE 1/8 | | 20c. LOCATION — City or Town, State BALTIMORE | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. Skaf Coleman | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229 | | | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anaplastic carcinoma thyroid DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death 1988 | | | |
| PART II. Other significant conditions contributing to death but not resulting in this underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Laurence R. Gallagher MD | | | | 29c. LICENSE NUMBER D01786 | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LAURENCE R. GALLAGHER MD, STAGNES MED, STAGNES MEDICAL CTR 3455 WILKENS AVE, BALTO 21229 MD | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 07 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Benison-Randall | | | | | |

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DATE

ST. ANNE'S HOSPITAL

BALTIMORE CITY

BALTIMORE CITY

USA

8199

WHITE

MEMBER

PLEASE PRINT NAME AND ADDRESS

PLEASE PRINT NAME AND ADDRESS

494

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours in accordance with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00278

| | | | | | | | | | |
|---|--|--|--|---|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Laura Lynch</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>1 6 94</i> | | 3. TIME OF DEATH <i>6 20 AM</i> | | | |
| 4. SOCIAL SECURITY NUMBER <i>219-44-7514</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>80</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>12-1-13</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>North Carolina</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Edenwald Retirement Center</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto</i> <i>Towson</i> | | | 9c. COUNTY OF DEATH <i>Balto</i> | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Baltimore</i> | | 10c. CITY, TOWN OR LOCATION <i>Towson</i> | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER <i>6710 Tweedbrook Road</i> | | | | 10f. ZIP CODE <i>21239</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4 years</i> College (14 or 5+) <i>4 years</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Liberation</i> | | | 16b. KIND OF BUSINESS/INDUSTRY <i>Southern High School</i> | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>George Barfoot</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Susan Culpepper</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Elizabeth DeSell</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>515 Holden Road Towson, MD 21286</i> | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Maplewood Cemetery 1/8/94</i> | | 20c. LOCATION — City or Town, State <i>Wilson, N.C.</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>severe chronic obstructive lung disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>② insulin dependent Diabetes mellitus</i> DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Dr. Albernie | | | | 29c. LICENSE NUMBER <i>D 29769</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/6/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>Dr. Albernie 516 N. Rolling Road Suite 204</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Sister Mary Dorothy Macciola | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 2, 1994 | | 3. TIME OF DEATH 6:05 PM | |
| 4. SOCIAL SECURITY NUMBER 219-26-4316 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 55 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 18, 1938 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Villa St. Michael | | 9b. CITY, TOWN OR LOCATION OF DEATH Emmitsburg | |
| 9c. COUNTY OF DEATH Frederick | | | | 10a. STATE Maryland | | 10b. COUNTY Frederick | |
| 10c. CITY, TOWN OR LOCATION Emmitsburg | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 333 South Seton Avenue | |
| 10f. ZIP CODE 21727 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College 3+ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Daughters of Charity | |
| 17. FATHER'S NAME (First, Middle, Last) Daniel G. Macciola | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy A. Bowinkelman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sister Camilla Harant | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 S. Seton Ave. Emmitsburg, MD. 21727 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Joseph Provincial House | | 20c. LOCATION — City or Town, State Emmitsburg, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William H. Patterson Supv. | | | | 22. NAME AND ADDRESS OF FACILITY Peters FH Gettysburg, Pa. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Malignant Glioblastoma of Thalamus b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John Davidson-Randall | | | | 29c. LICENSE NUMBER D18705 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00280 | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) William Paul Manion | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | | | 3. TIME OF DEATH 1025 a.m. | | | |
| 4. SOCIAL SECURITY NUMBER 232-07-3643 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/21/13 | | 8. BIRTHPLACE (State or Foreign Country) Clarksburg, WVa. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Fallston General Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Fallston, MD | | | | 9c. COUNTY OF DEATH Harford | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Bel Air | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 202 L. Burkwood Ct. | | | | 10f. ZIP CODE 21015 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 College (1-4 or 5+) 3 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Martin Marietta Denver | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Lee Manion | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Mary Moogan | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) David L. Manion | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Joppa Fram Rd. Joppa, Md. 21085 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory | | DATE 1/5/94 | | 20c. LOCATION — City or Town, State baltimore, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE E.F. Lassahn Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY E.F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>cardiac arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>C.V.A.</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>aspiration pneumonia</u> <u>hx of CVA's</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David S. Dunn | | | | 29c. LICENSE NUMBER D32299 | | | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID S. DUNN 113 Belaire Rd | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1/JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RUTH E. MACKULA | | | | 2. DATE OF DEATH MONTH 01 DAY 05 YEAR 94 | | 3. TIME OF DEATH 12:24 P.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 217 26 8006 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/17/1923 | | 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH ===== | | | |
| 10a. STATE Maryland | | 10b. COUNTY ===== | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3817 St. Victor Street | | | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Packer | | 16b. KIND OF BUSINESS/INDUSTRY Glass Company | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Hercie White | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Mills | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Julian Mackula | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3817 St. Victor Street Baltimore, Maryland 21225 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. State Veterans Cem. 1/10 | | DATE | | 20c. LOCATION — City or Town, State Crownsville, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donna M. Zramkowski | | | | 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO INQUIRY | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Print name) 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 1-5-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | | | | | 32. REGISTRAR'S SIGNATURE Julia Burdon-Andall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Raphael Robert Mosca</u> <u>RAPHAEL MOSCA</u> | | | | 2. DATE OF DEATH MONTH <u>JANUARY</u> DAY <u>6</u> YEAR <u>1994</u> | | 3. TIME OF DEATH <u>10 10 PM</u> | |
| 4. SOCIAL SECURITY NUMBER <u>213-07-2821</u> | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>79</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>8-1-1914</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Good Samaritan Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u> | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>Baltimore</u> | | 10c. CITY, TOWN OR LOCATION <u>Dundalk</u> | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <u>2932 Sollers Point Road</u> | | | | 10f. ZIP CODE <u>21222</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>United States</u> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WW II</u> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th Grade</u> College (1-4 or 5+) <u>College</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Electrician</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>Construction</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Gaetano Mosca</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Rose Maresca</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Sam C. Mosca</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1709 Manor Road Dundalk, Maryland 21222</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Oak Lawn Cemetery 1/10/1994</u> | | 20c. LOCATION — City or Town, State <u>Baltimore, Maryland</u> | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <u>SEPSIS (STAPHYLOCOCCUS)</u> | | | | Approximate Interval Between Onset and Death <u>10 DAYS</u> | |
| | | b. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> | | | | <u>10 DAYS</u> | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. <u>ORGANIC BRAIN SYNDROME</u> | | | | <u>2 YEARS</u> | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ARRHYTHMIA</u> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature] MBChB</u> | | | | 29c. LICENSE NUMBER <u>BEEPER 020</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>JANUARY 6TH 1994</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BOULEVARD BALTIMORE MD 21237</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 10 1994</u> | | 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|---|---|--------------------------------|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Sicil Martin</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>1 - 9 - 94</i> | | 3. TIME OF DEATH <i>12:45 P.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>212-74-3595</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>101</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) <i>01 27 1892</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i> | | | | 9. COUNTY OF DEATH <i>---</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Meridian Hsg. Center 6000 Bellona Ave</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i> | | 9c. COUNTY OF DEATH <i>---</i> | |
| 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY <i>---</i> | | 10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>6000 BELLONA AVENUE</i> | | | | 10f. ZIP CODE <i>21212</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>UNKNOWN</i> College (1-4 or 5+) <i>---</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOUSEWIFE</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>---</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>ELBERT JAMES WINDSOR</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>EDITH MELBOURN SHANE</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>LINDA JOHNSON</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6202 MARLORA ROAD, BALTIMORE, MARYLAND 21237</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>LORRAINE PARK CEMETERY 1/12/94</i> | | 20c. LOCATION — City or Town, State <i>BALTIMORE, MARYLAND</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>A. Alan Seitz, Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>A. ALAN SEITZ, JR. FUNERAL HOME 21211 3818 ROLAND AVENUE, BALTIMORE, MARYLAND</i> | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's Disease</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph W. Ferblaz</i> | | | | 29c. LICENSE NUMBER <i>D22334</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>10 Jan 94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Joseph W. Ferblaz 7801 York Rd Towson Md 21204</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Ridgely</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00284

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MORRIS MOLOFSKY | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 9:30 A.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 217-07-4725 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03/08/1905 | | 8. BIRTHPLACE (State or Foreign Country) RUSSIA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | 9c. COUNTY OF DEATH Baltimore | | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10a. STATE MD | | 10b. COUNTY Baltimore | | 10e. STREET AND NUMBER 8115 McDonough Road | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MANUFACTURER | | 16b. KIND OF BUSINESS/INDUSTRY CLOTHING | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH MOLOFSKY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CELIA KLEINMAN | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS. ROSE MOLOFSKY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8115 MCDONOUGH RD., BALTIMORE, MD 21208 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOSES MONTEFIORE | | DATE 1-7-94 | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen Swenson | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic colon cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 5 years | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Bruce Rosenberg MD | | | | | | 29c. LICENSE NUMBER D24121 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRUCE ROSENBERG 1134 YORK RD LUTHERVILLE, MD 21093. | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE John Davidson | | | | | | | | | |

10300 10

DEPT. OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WYOMING
SANDWICH MOUNTAIN

WYOMING

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 94 00285

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RACHEL MOSHAN | | | | 2. DATE OF DEATH MONTH JANUARY DAY 5 YEAR 1994 | | | | 3. TIME OF DEATH 641 P M | |
| 4. SOCIAL SECURITY NUMBER 077-56-9370 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | |
| 7. DATE OF BIRTH (Month, Day, Year) AUGUST 2 1920 | | | | 8. BIRTHPLACE (State or Foreign Country) RUSSIA | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH USA | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3601 FORDS LA, APT 722 | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER | | | | 15b. KIND OF BUSINESS/INDUSTRY EDUCATION | | | |
| 17. FATHER'S NAME (First, Middle, Last) ALEXANDER MUCHNIK | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLIE GREENBERG | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS SOPHIA KIZHNER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 CHERRY CHAPEL RD. REISTERSTOWN, MD 21136 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) BALTIMORE HEBREW 1/7/94 | | DATE | | 20c. LOCATION — City or Town, State REISTERSTOWN MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sophia L. Kizhner</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. large cell lymphoma recurrence DUE TO (OR AS A CONSEQUENCE OF): c. large cell lymphoma in remission DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death 1 week unknown 11 years | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. anemia metastatic cancer to brain | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>James Boyer MD PhD PGY-I</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) JANUARY 5 1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LINNEA BOYER SINAI HOSPITAL | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000

(A)

94 00286

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Willie A. Manning</i> | | | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>3</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>2:20 P M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>230-16-0631</i> | | 5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>72</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>12/30/1921</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Pa</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Good Samaritan Hospital</i> | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Balto</i> | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE <i>Md</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Balto</i> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>5324 Cordelia Ave</i> | | | | 10f. ZIP CODE <i>21215</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Painter</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Bethlehem Steel</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>John H. Manning</i> | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary E. Bonner</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Willie L. Manning</i> | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1323 E. 35th St Balto, Md 21218</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest 1/10/94</i> | | 20c. LOCATION — City or Town, State <i>Owings Mills, Md</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sala March</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>March F. H. West 4300 Wabash Ave</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiopulmonary arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Advanced Carcinoma of pancreas</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i> | | | | | | | | | |
| Approximate interval Between Onset and Death | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. Nolen</i> | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>1/13/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



(3)

20-10-1945

64

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 94 00287

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Pelzer O McDonald</i> | | | | 2. DATE OF DEATH MONTH <i>15</i> DAY <i>94</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>11:45 PM</i> | |
| 4. SOCIAL SECURITY NUMBER <i>250-58-9396</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>61</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>2-1-32</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>NORTHWEST HOSPITAL CENTER</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTO</i> | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>MD</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>BALTO</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>3011 OAKFORD AVE</i> | | | | 10f. ZIP CODE <i>21215</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>11TH</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HEALTH AIDE</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>ROSEWOOD CENTER</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>JACKSON MONROE</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ELIZABETH PETERSON</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>ANNIE MCDONALD</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1824 BOLTON ST. BALTO, MD 21217</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> 2 Cremation <input type="checkbox"/> 3 Removal from State <input type="checkbox"/> 4 Donation <input type="checkbox"/> 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <i>ARBUTUS MEMORIAL PK 11194</i> | | 20c. LOCATION — City or Town, State <i>ARBUTUS, MD</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sola March</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>March F/H WEST 4300 WABASH AVE</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Bilateral Hemispheric Infarct</i> | | | | | | | |
| Due to (or as a consequence of): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| Due to (or as a consequence of): | | | | | | | |
| Due to (or as a consequence of): | | | | | | | |
| Due to (or as a consequence of): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> 2 ER/Outpatient <input type="checkbox"/> 3 DOA OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> 1 Natural <input type="checkbox"/> 5 Pending Investigation <input type="checkbox"/> 2 Accident <input type="checkbox"/> 6 Could not be determined <input type="checkbox"/> 3 Suicide <input type="checkbox"/> 4 Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elizabeth M. Burke MD</i> | | | | 29c. LICENSE NUMBER <i>D36872</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/5/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Elizabeth M. Burke, Northwest Hosp & Center</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Rodell</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18800 12

Handwritten signature

10010 / 741



REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

105800 07

105800 07

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

64 00289

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Martha Lee McCadden</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>9</i> YEAR <i>1994</i> | | 3. TIME OF DEATH <i>10:35</i> M | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>219-10-6525</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>68</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>4-11-25</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>W. Va.</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Fallston Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Fallston</i> | | | | 9c. COUNTY OF DEATH <i>Harford</i> | | | |
| 10a. STATE <i>Md.</i> | | 10b. COUNTY <i>Harford</i> | | 10c. CITY, TOWN OR LOCATION <i>Edgewood</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <i>306 Kennord Ave</i> | | | | 10f. ZIP CODE <i>21040</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i></i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Hairdresser</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Russell Riggs</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lenna</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Harry F. McCadden</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>306 Kennord Ave Edgewood Maryland 21040</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oak Lawn</i> | | DATE <i>1/12</i> | | 20c. LOCATION — City or Town, State <i>Baltimore, Md.</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Colt Connelly</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Connelly Funeral Home of Dundalk 7110 Sollers Pt. Rd. Dundalk 21222</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Terminal Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Congestive heart failure, Cor pulmonale</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Cachexia</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Severe pulmonary emphysema, bronchiectasis</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Bilateral Pneumonia, pleural effusion</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Albert S. C. Sun, MD</i> | | | | 29c. LICENSE NUMBER <i>MD0018779</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>Jan 9, '94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Albert S. C. Sun, MD. 1800 HARFORD RD., FALLSTON, MD 21047</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John A. Anderson</i> | | | | | | | |

28500 45

RECEIVED

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00290

| | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Harry Mowry, JR. | | | | 2. DATE OF DEATH MONTH JANUARY DAY 5 YEAR 1994 | | | | 3. TIME OF DEATH 00-10 hrs. M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-16-9188 | | | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs., last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) AUG. 21, 1923 | | 8. BIRTHPLACE (State or Foreign Country) BALTO. MD. | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | | 9c. COUNTY OF DEATH - | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE CO. | | | | 10c. CITY, TOWN OR LOCATION PARKVILLE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3412 UPTON ROAD | | | | | | 10f. ZIP CODE 21234 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: - | | | | 14. RACE — American-Indian, Black, White, other— Specify: WHITE | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) - | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONTRACT MANAGER | | | | 16b. KIND OF BUSINESS/INDUSTRY MARTIN MARETTA | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) HARRY MILTON MOWRY, SR. | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ANN HARE | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) BETH L. MOWRY (AVERIL) | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS BOX 10E | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) - | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEM. 1-8 | | | | 20c. LOCATION — City or Town, State PARKVILLE, MD. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE J. J. Gay LIC# MARKET | | | | | | 22. NAME AND ADDRESS OF FACILITY EVANS FUNERAL CHAPEL 5800 HARTFORD ROAD PARKVILLE | | | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular accident. Approximate Interval Between Onset and Death 12 days. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { a. Small cell ca of lung. DUE TO (OR AS A CONSEQUENCE OF): 3 weeks. b. Brain metastasis DUE TO (OR AS A CONSEQUENCE OF): 3 weeks. c. - DUE TO (OR AS A CONSEQUENCE OF): - d. - DUE TO (OR AS A CONSEQUENCE OF): - | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - | | | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) - | | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) - | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED - | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) - | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) - | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER R. M. D. PGY-I | | | | | | 29c. LICENSE NUMBER DEAN: 243-8946 -F9 | | | | 29d. DATE SIGNED (Month, Day, Year) 1/5/93 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAN JAN PAUL, 201E, UNION MEMORIAL HOSPITAL BALTIMORE, MD 21218 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia K. ... | | | | | | | | | | | |

TO THE HOSPITAL: For attending physician: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: The law requires that the death certificate be completed and filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00291

| | | | | | | | | | | | |
|---|--|--|---|---|-------------------------------|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CARRIE MCCOY | | | | 2. DATE OF DEATH MONTH 1 DAY 6 YEAR 94 | | 3. TIME OF DEATH 1:15 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 218-18-9812 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/9/1921 | | 8. BIRTHPLACE (State or Foreign Country) N. CAROLINA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) MERCY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH BALTIMORE | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 633 AISQUITTH STREET APT. 10B | | | | 10f. ZIP CODE 21202 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) N/A | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC | | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) MATTHEW MCCOY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CALLIE SMITH | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) CHARLOTTE PRICE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 N. ELLWOOD AVENUE/BALTIMORE, MD 21213 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK | | | DATE | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MD | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVENUE | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE ORGAN FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. END STAGE RENAL DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Juan D. Montoya - SURGICAL RESIDENT | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JUAN D. MONTOKA MD. | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | | 32. REGISTRAR'S SIGNATURE | | | | | | |

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

91, 00292

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN E. MORSE JR. | | | | 2. DATE OF DEATH MONTH 1 DAY 8 YEAR 94 | | 3. TIME OF DEATH 4:30 A.M. | |
| 4. SOCIAL SECURITY NUMBER 219-65 4883 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 01/12/1915 | |
| 8a. FACILITY NAME (If not institution give street and number) St Agnes Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO | | 9c. COUNTY OF DEATH US17 | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY BALTO | | 10c. CITY, TOWN OR LOCATION BALTO | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER 23 DUNMORE RD | | | | 10f. ZIP CODE 21228 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) INSURANCE AGENT | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) INSURANCE | | 16b. KIND OF BUSINESS/INDUSTRY INSURANCE | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN E. MORSE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GRACE ZELL | | | |
| 19a. INFORMANT'S NAME (Type/Print) CATHERINE MORSE (WIFE) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 DUNMORE ROAD CATONSVILLE, MARYLAND 21228 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LORRAINE PARK CEMETERY 1/11/94 | | 20c. LOCATION — City or Town, State WOODLWAN MARYLAND | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | |
| 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure Due to (or as a consequence of): b. Aortic stenosis Due to (or as a consequence of): c. Dilated cardiomyopathy Due to (or as a consequence of): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER MO | | | | 29c. LICENSE NUMBER 043159 | | 29d. DATE SIGNED (Month, Day, Year) 1/8/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00293 | |
|--|--|--|---|---|-----------------------------------|----------|--|
| | | CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Kevin J. Martin</i> KEVIN J. MARTIN | | 2. DATE OF DEATH MONTH <i>01</i> DAY <i>08</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>1:30 P</i> M | | | |
| 4. SOCIAL SECURITY NUMBER 220-72-2078 | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 33 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 08-16-60 | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL RESIDENCE OF DECEDENT | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE MARYLAND | 10b. COUNTY BALTIMORE | 10c. CITY, TOWN OR LOCATION WOODLAWN | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 2115 N. ROLLING ROAD | | 10f. ZIP CODE 21244 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) REGISTERED NURSE | | | |
| 16b. KIND OF BUSINESS/INDUSTRY HEALTH CARE | | 17. FATHER'S NAME (First, Middle, Last) WILLIAM C. MARTIN SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE R. ALAIMO | | | |
| 19a. INFORMANT'S NAME (Type/Print) WILLIAM C. MARTIN SR. (FATHER) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 N. ROLLING ROAD BALTIMORE, MARYLAND 21244 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY CEMETERY 1/12/94 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>metastatic squamous carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joe I. Turner MD</i> | | 29c. LICENSE NUMBER <i>resident</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/8/94</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Joe I. Turner 1022 S. Green St. Balt MD 21201</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00294 | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|--|--|--------------------------------------|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Agnes Nuesslein | | | | 2. DATE OF DEATH MONTH 11 DAY 16 YEAR 1994 | | | | 3. TIME OF DEATH 2045 M | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 218-09-7042 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) October 8, 1902 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Church Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto. City | | | | 9c. COUNTY OF DEATH | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Balto. | | 10c. CITY, TOWN OR LOCATION Dundalk | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | |
| 10e. STREET AND NUMBER 8 Graywood Road | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 3 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Factory Worker | | 15b. KIND OF BUSINESS/INDUSTRY National Can Co. | | | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Kedzierski | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anastasia Sludrinska | | | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joyce McGee | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14307 Dairydale Road Baldwin, Md. 21013 | | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 1/8/94 | | 20c. LOCATION — City or Town, State Towson, Md. 21204 | | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald E. Chalko | | | | 22. NAME AND ADDRESS OF FACILITY 1050 York Rd. 21204 Ruck Towson Funeral Home, Inc. | | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Pulm. Edema Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. ASCD b. c. d. Approximate Interval Between Onset and Death few hours many years | | | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Tuberculosis Chronic obstructive Lung disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | | | |
| 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER R. A. W. [Signature] Med. Specialist | | 29c. LICENSE NUMBER D40356 | | 29d. DATE SIGNED (Month, Day, Year) 11/6/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W. A. V. [Signature] 100 N. Broadway Balto. Md. 21231 | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | |

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ASP

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00295

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) KWADWO ADWO KALOMO ONYANGO | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 06 1994 | | 3. TIME OF DEATH 3:52 A M | |
| 4. SOCIAL SECURITY NUMBER 215-86-5765 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 22 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-18-71 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) MARYLAND SHOCK TRAUMA | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MD. | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 8 BENKERT ST. | |
| 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12TH College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) KWABENA ONYANGO | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BEULAH MILLER | | | |
| 19a. INFORMANT'S NAME (Type/Print) BEULAH MILLER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 343 MELVIN AVE. APT. B 21228 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) BALTIMORE MD 1/10/94 | | | |
| 20c. LOCATION — City or Town, State BALTIMORE MD | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE GARY L. MARCH Funeral Home Inc, 270 FREDERICK PASS 71229 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE GUN SHOT WOUNDS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) 1-6-1994 | | 28b. TIME OF INJURY 2:04 AM | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED SUBJECT WAS SHOT | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) BALTO, MD 3300 BLK OLD FREDERICK RD | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Wayne D. Hume | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) 01-06-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Maryland A. Korrell 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

TO THE HOSPITAL OR OTHER FACILITY: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00296

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Marie Ongsingco | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN 7 1994 | | | | 3. TIME OF DEATH 1307 M | | | |
| 4. SOCIAL SECURITY NUMBER 215-30-9647 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03-15-24 | | 8. BIRTHPLACE (State or Foreign Country) HAITI | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | | 9c. COUNTY OF DEATH n/a | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 610 MELVILLE AVENUE | | | | 10f. ZIP CODE 21218 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: HAITIAN WEST INDIES | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) n/a College (1-4 or 5+) n/a | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) EDUCATOR - LIBRARIAN | | | | 16b. KIND OF BUSINESS/INDUSTRY SOJOURNER DOUGLAS COLLEGE | | | |
| 17. FATHER'S NAME (First, Middle, Last) JEAN JACQUES | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BIEN AMIE | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) ANTONIO ONGSINGCO | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 CLOVER COURT, NEW LONDON, CONNECTICUT 06320 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK 01-08 | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeresad Chapman | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): b. Subdural Hematoma DUE TO (OR AS A CONSEQUENCE OF): c. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 9 minute 30 hours 40 hours | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Subdural Hematoma SP CRANIOTOMY + Evacuation OF Hematoma | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER PHILIPPE M. EUDARIC, MD | | | | 29c. LICENSE NUMBER DEA ATZY38946E17 | | | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) UNIV. OF MD Fan. Med. 29 S. Paca B'mare | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | |

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00297

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) FANNIE R. OPPEL | | | | 2. DATE OF DEATH MONTH 01 DAY 07 YEAR 94 | | 3. TIME OF DEATH 2:43 A M | |
| 4. SOCIAL SECURITY NUMBER 264843694 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 97 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 01/18/1899 | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH --- | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 509 E. Joppa Road | | | | 10f. ZIP CODE 21286 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th. Grade College (1-4 or 5+) --- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Armistead Morehead Churchill | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lola Montez Patterson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Wallace C. Oppel, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 3rd Ave. Fairhaven C-104 Sykesville, MD 21784 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 1/8 | | 20c. LOCATION — City or Town, State Baltimore, MD | | 20d. DATE --- | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., Inc. 299 Frederick Road Balto., MD 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. Atrial Fibrillation DUE TO (OR AS A CONSEQUENCE OF): d. Acute Renal Failure | | | | | | | Approximate Interval Between Onset and Death 4 days |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation Acute Renal Failure | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Omair Ghandour, M.D. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) OMAIR GHANDOUR / GOOD SAMARITAN HOSPITAL | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the records of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2400

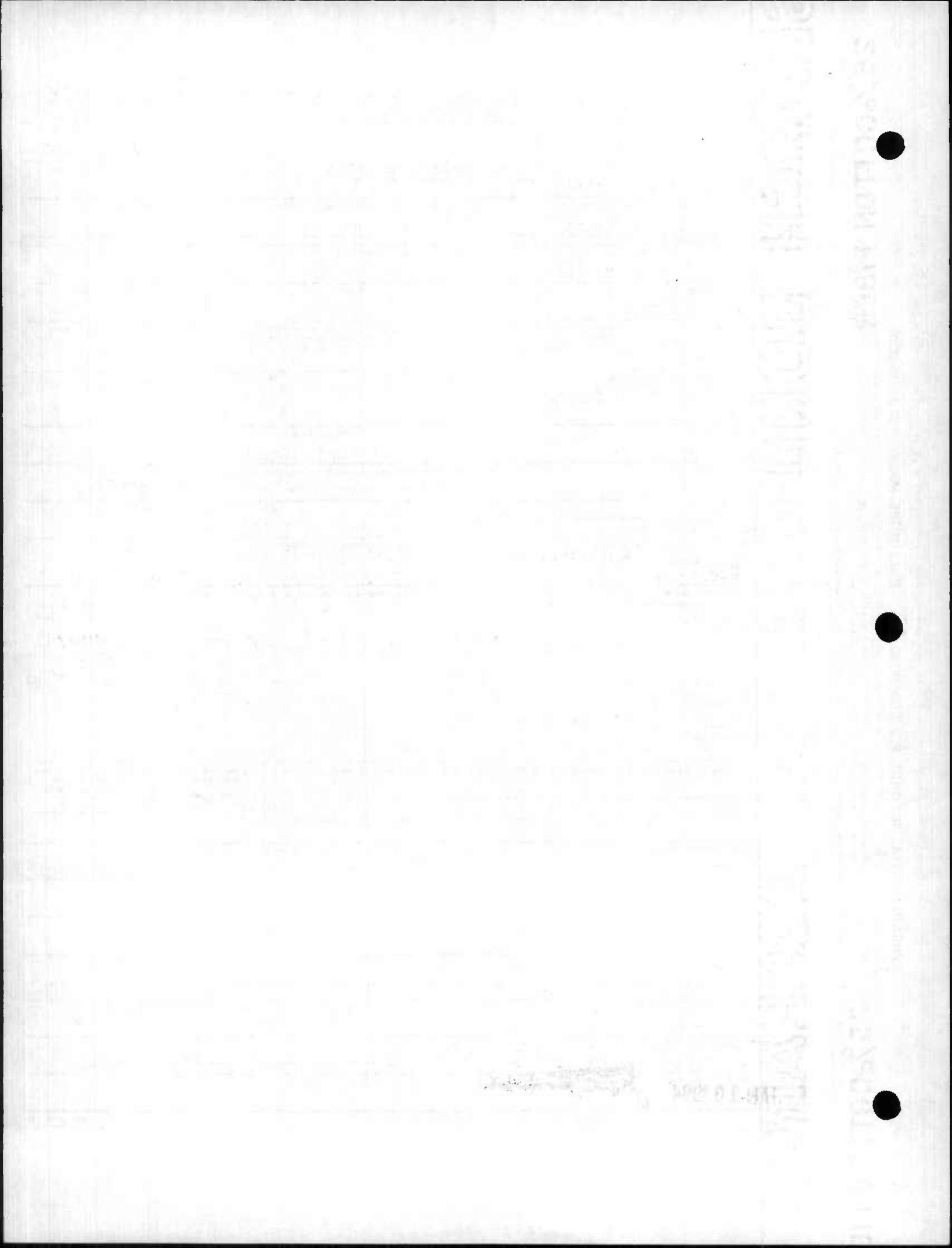
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94-00298

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|----------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LEONA M PALEN | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 06 94 | | 3. TIME OF DEATH 1320 M | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-18-3160 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 18, 1921 | | 8. BIRTHPLACE (State or Foreign Country) MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital & Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH N/A | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE MD | | 10b. COUNTY Baltimore City | | 10c. CITY, TOWN OR LOCATION Baltimore | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1642 Ceddox Street | | 10f. ZIP CODE 21226 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 15b. KIND OF BUSINESS/INDUSTRY own home | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Theodore Appel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Feehly | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Leona Herold | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 Riviera Drive, Pasadena, MD 21122 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery | | DATE 1/10 | | 20c. LOCATION — City or Town, State Glen Burnie, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven H. Williams | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave. Baltimore, MD 21225 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Hypertension</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death months 2 years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide a <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER S. R. GELBERMAN MD | | | | 29c. LICENSE NUMBER DE 8387 | | 29d. DATE SIGNED (Month, Day, Year) 1-7-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. R. GELBERMAN MD 4710 Remington Ave (Baltimore 21226) | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | | | | | | | | |



94 00299

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WALTER L. RUMBLEY | | | | 2. DATE OF DEATH MONTH January DAY 7 YEAR 1994 | | 3. TIME OF DEATH 4:35 A.M. | |
| 4. SOCIAL SECURITY NUMBER 214 07 9500 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MAY 29, 1920 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | 9a. FACILITY NAME (If not institution, give street and number) 6000 SAMARITAN HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION PARKVILLE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 2304 FOSTER AVE | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YRS. College (14 or 5+) LETTER CARRIER | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. POST OFFICE | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) WALTER RUMBLEY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) PHILA TURNER | | | |
| 19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH | | DATE 1994 | | 20c. LOCATION — City or Town, State ROSDALE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MOURNERS 8800 HARFORD ROAD - PARKVILLE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Amyloidosis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death 3 years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Omair Ghandour, M.D. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) January 7/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) OMAIR GHANDOUR / 6000 SAMARITAN HOSPITAL | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00300

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Fletcher C. Russell Sr.</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> - DAY <i>4</i> - YEAR <i>94</i> | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>73</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>9-12-1920</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> |
| 9a. FACILITY NAME (If not institution, give street and number) <i>1312 Wirton Street</i> | | | | 9b. CITY/TOWN OR LOCATION OF DEATH <i>Baltimore City</i> | | 9c. COUNTY OF DEATH | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY | | 10c. CITY/TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>1312 Wirton Street</i> | | | | 10f. ZIP CODE <i>21202</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II Army</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>MUSICIAN</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Fletcher W. Russell</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Attie Thomas</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Attie Smith</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>701 Arlington Ave. Balt., Md. 21217</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of institution, crematory or other place) <i>Crownsville Cem. 17 Crownsville Md.</i> | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Joseph L. Russ Funeral Home 2232 W. North Ave. Balt., Md. 21246</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>esophageal carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death <i>2 years</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alan Duncan M.D.</i> | | | | 29c. LICENSE NUMBER <i>D43050</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/7/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Alan Duncan M.D. 1000 E. Eager St. Baltimore, MD 2120</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>1/7 JAN 10 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>Julia Swindon-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00301 | |
|--|--|--|---|---|---|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT M. RISING | | | | 2. DATE OF DEATH MONTH 1 DAY 6 YEAR 94 | | 3. TIME OF DEATH 10:45 P M | |
| 4. SOCIAL SECURITY NUMBER 212 - 09 - 2637 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 76 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 07-01-17 | 8. BIRTHPLACE (State or Foreign Country) MASSACHUSETTS | | |
| 9a. FACILITY NAME (If not institution, give street and number) 4877 ILCHESTER ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ELLCOTT CITY | | 9c. COUNTY OF DEATH HOWARD | |
| 10a. STATE MARYLAND | | 10b. COUNTY HOWARD | | 10c. CITY, TOWN OR LOCATION ELLCOTT CITY | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4877 ILCHESTER ROAD | | | | 10f. ZIP CODE 21043 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 5 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) METROLOGIST | | 16b. KIND OF BUSINESS/INDUSTRY U.S. NAVY | | | |
| 17. FATHER'S NAME (First, Middle, Last) ROBERT M. RISING SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH KAHLER | | | |
| 19a. INFORMANT'S NAME (Type/Print) MINNA RISING (WIFE) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4877 ILCHESTER ROAD ELLCOTT CITY MARYLAND 21043 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE CEMETERY 01/10/94 | | 20c. LOCATION — City or Town, State DORSEY, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITKZE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE, MARYLAND | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Severe tumor</i> b. <i>Posttraumatic bleeding</i> c. <i>Chronic heart failure</i> d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death <i>years</i> <i>days</i> <i>days</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | |
| 29c. LICENSE NUMBER 024781 | | | | | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00302

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|----------------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DORIS C. ROSENSTEIN | | | | 2. DATE OF DEATH JANUARY 3, 1994 YEAR | | 3. TIME OF DEATH 10:35 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER 033-16-9994 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH MAY 16, 1906 | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 9a. FACILITY NAME (If not institution, give street and number) PIKESVILLE NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH PIKESVILLE | | | 9c. COUNTY OF DEATH BALTIMORE | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION PIKESVILLE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 7 SUDBROOK LANE | | | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY AT HOME | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH GOLDHAGEN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) REBECCA HUIT | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) DR BERYL ROSENSTEIN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3316 WOODVALLEY DRIVE BALTIMORE, MD 21208 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) JEWISH CEMETERY | | DATE 1-6-94 | | 20c. LOCATION — City or Town, State WOBURN, MASSACHUSETTS | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joel D Lewis | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): b. Generalized Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death years years | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Vascular Disease | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Sheldon Goldgeier M.D. | | | | 29c. LICENSE NUMBER D02397 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sheldon Goldgeier M.D. 711 W 40 th Street Baltimore MD 21211 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

CHITREND

A

94-0030-005

M.L.JR.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00303

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT E. ROGERS | | | | 2. DATE OF DEATH MONTH 01 DAY 02 YEAR 94 | | 3. TIME OF DEATH 1:16 P.M. | |
| 4. SOCIAL SECURITY NUMBER 220-98-2484 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 22 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-10-1971 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. COUNTY OF DEATH BALTIMORE | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 208 ELINOR AVENUE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH BALTIMORE | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Overlea | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 208 Elinor Avenue | | | | 10f. ZIP CODE 21236 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) 2 years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assistant Manager | | 16b. KIND OF BUSINESS/INDUSTRY Chic-Fil-A | | | |
| 17. FATHER'S NAME (First, Middle, Last) C. Wallace Rogers | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Caroline J. Claridge | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Janice M. Meisel | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3419 Moultrie Place Balto., Md. 21236 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Cemetery 1-6-94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lassahn Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Gunshot Wound of Head</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>Head only</i> |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 01/02/94 | | 28b. TIME OF INJURY unknown | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED Subject shot self | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 208 ELINOR AVENUE (HOME) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 208 ELINOR AVENUE | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/03/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>THEODORE M. KING</i> 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE <i>Julie Davidson-Rodale</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

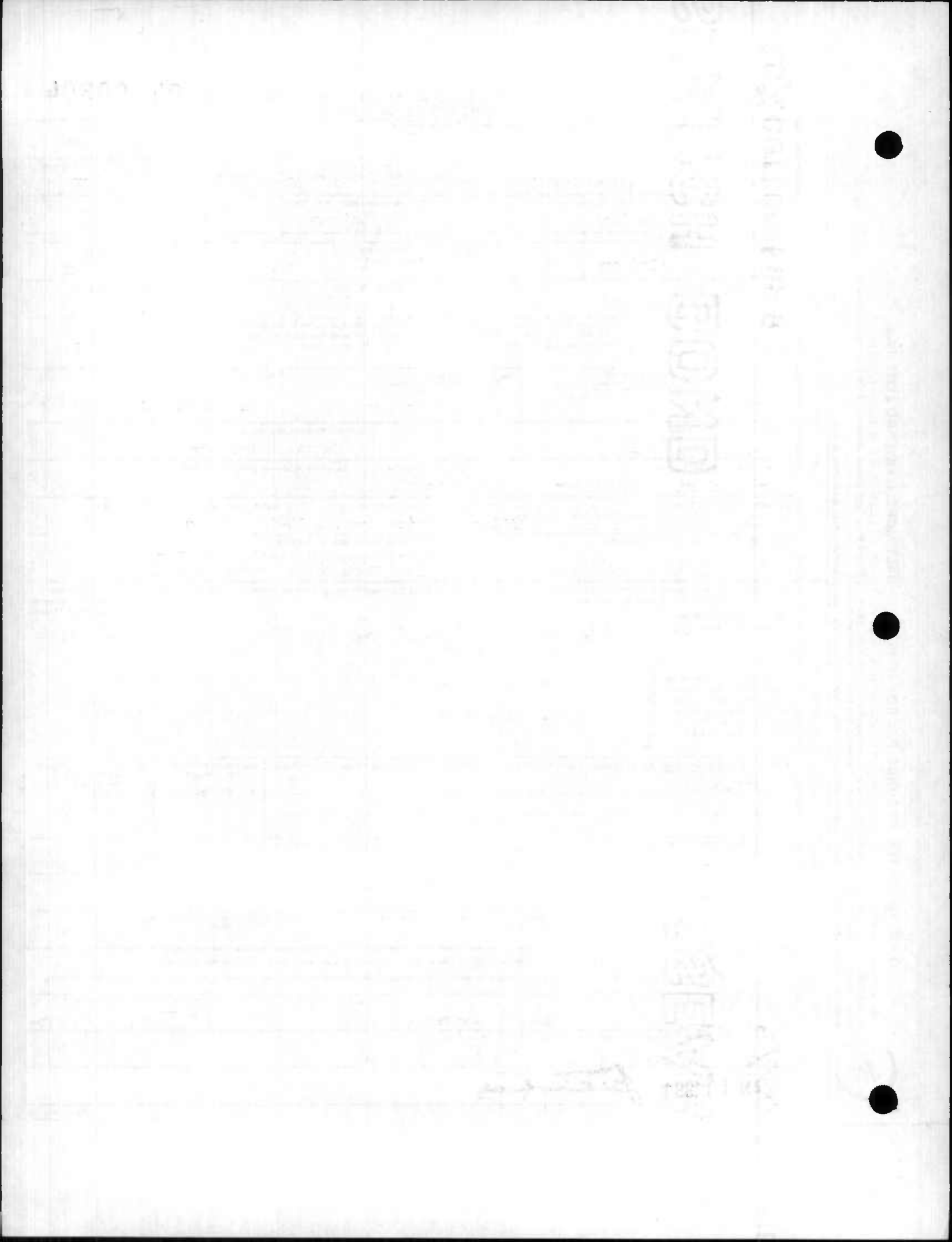
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00304

| | | | | | | | | | | | |
|---|--|--|---|---|---------------------------------|---|--|---|-----------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Hellen L Sullivan</u> | | | 2. DATE OF DEATH MONTH <u>January</u> DAY <u>7</u> YEAR <u>1994</u> | | | 3. TIME OF DEATH <u>22:40</u> M | | | | | |
| 4. SOCIAL SECURITY NUMBER <u>056-05-7711</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>74</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>June 27, 1919</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>New York</u> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Sinai Hospital</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u> | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE <u>Maryland</u> | | 10b. COUNTY <u>Baltimore</u> | | 10c. CITY, TOWN OR LOCATION <u>White Hall</u> | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <u>2800 Anderson Road</u> | | | | 10f. ZIP CODE <u>21161</u> | | | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u> | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Legal Secretary</u> | | | 16b. KIND OF BUSINESS/INDUSTRY <u>Fletcher School of Law</u> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Josef Edquist</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Hannah Nordstrom</u> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Mary Catherine Schweitzer</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Same As #10</u> | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Hilltop Service Corp. 1-11-94</u> | | | 20c. LOCATION — City or Town, State <u>Towson, Maryland</u> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Wallace S. Brooke Jr.</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204</u> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Metastatic Breast Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u></u> DUE TO (OR AS A CONSEQUENCE OF): c. <u></u> DUE TO (OR AS A CONSEQUENCE OF): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death <u>2 years</u> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Anemia</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Medical Intern</u> | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <u>January 7, 1994</u> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Sam Sencil, D.O., Sinai Hospital</u> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 10 1994</u> | | | | 32. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00305

| | | | | | | | | |
|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Melton Simpson</u> | | | | 2. DATE OF DEATH MONTH <u>1</u> DAY <u>9</u> YEAR <u>94</u> | | 3. TIME OF DEATH <u>10:12 AM</u> | | |
| 4. SOCIAL SECURITY NUMBER <u>219-22-1072</u> | | 5. SEX <u>1</u> M <u>2</u> F | 6. AGE (In yrs. last birthday) <u>63</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>7-29-30</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>S.C.</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Mercy Hospital Center</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Balto</u> | | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | | |
| 10a. STATE <u>Md</u> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <u>Catonsville</u> | | | 10d. INSIDE CITY LIMITS? <u>1</u> YES <u>2</u> NO | |
| 10e. STREET AND NUMBER <u>1300 Pleasant Valley Drive</u> | | | | 10f. ZIP CODE <u>21228</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | |
| 11. MARITAL STATUS <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> YES <u>2</u> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> YES <u>2</u> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Clarence Simpson</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Elnora Franklin</u> | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>Rosetta H. Simpson</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1300 Pleasant Valley Dr. Catonsville, Md 21228</u> | | | | |
| 20a. METHOD OF DISPOSITION <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Baltimore Nat Cem 11/2/94</u> | | 20c. LOCATION — City or Town, State <u>Balto, Md</u> | | 20d. DATE <u>11/2/94</u> | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>George A. Thompson Jr</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>March F.H. West 4300 Wabash Ave Balto, Md 21215</u> | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death | |
| a. <u>aspiration pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| b. <u>Gastric Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| d. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>dehydration</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <u>1</u> YES <u>2</u> NO | |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <u>1</u> YES <u>2</u> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <u>1</u> YES <u>2</u> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA OTHER: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>8</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? <u>1</u> YES <u>2</u> NO | | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) <u>1</u> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Theodora Balis MD - Intern</u> | | | | | | |
| | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <u>1-9-94</u> | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Theodora Balis - 603-I Churchill Rd. Bel Air, Md 21014</u> | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 10 1994</u> | | 32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u> | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00306 | |
|---|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | REG. NO. | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Irene Elizabeth Savage</i> | | 2. DATE OF DEATH MONTH DAY YEAR <i>1 2 94</i> | | 3. TIME OF DEATH <i>5:53 PM</i> | | | |
| 4. SOCIAL SECURITY NUMBER <i>215-14-8900A</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>74</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>11-19-1919 Maryland</i> | |
| 8a. FACILITY NAME (If not institution, give street and number) <i>Sinai Hosp.</i> | | 8b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i> | | 8c. COUNTY OF DEATH | | | |
| 9. RESIDENCE OF DECEDENT | | 10a. STATE <i>Maryland</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>701 Arlington Ave. Apt 203</i> | | 10f. ZIP CODE <i>21217</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Charles J. Savage</i> | | 17. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Bishop</i> | | 18. INFORMANT'S NAME (Type/Print) <i>Mrs. Eunice Savage</i> | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>701 N. Arlington Ave. Baltimore Md 21217</i> | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of interment) <i>Arboretum Memorial Park 1/2</i> | | 20c. LOCATION — City or Town, State <i>Balt. Co. Md.</i> | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i> | |
| 22. NAME AND ADDRESS OF FACILITY <i>Joseph L. Russ Funeral Home</i> | | 22. ADDRESS OF FACILITY <i>2322 W. North Ave. Balt. Md 21216</i> | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary artery disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Cerebrovascular accident</i> | | Approximate interval between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) <i>1 2 94</i> | |
| 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Savage</i> | | 29c. LICENSE NUMBER <i>D30641</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/10/94</i> | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>221 N. Eutaw St. Ramash Sabapath: M.D.</i> | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | 33. REGISTRAR'S TITLE <i>Registrar</i> | | | |

338000 00

3

John H. Johnson

JAN 10 1934

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH C. SHALLENBERGER JR. | | | | 2. DATE OF DEATH MONTH 9 DAY 6 YEAR 94 | | 3. TIME OF DEATH 6:50P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-14-4731 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5/8/22 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE MARYLAND | | | 10b. COUNTY BALTIMORE | | | 10c. CITY, TOWN OR LOCATION CATONSVILLE | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 6117 MOOREFIELD ROAD | | | | 10f. ZIP CODE 21228 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W W II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COMPUTER TECHNICIAN | | | 16b. KIND OF BUSINESS/INDUSTRY B & O RAILROAD | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH C. SHALLENBERGER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET TAYLOR | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) JAMES SHALLENBERGER (BROTHER) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 N, CHAPELGATE LANE BALTIMORE, MARYLAND 21229 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery or other place) GARRISON FOREST 01/12/94 | | DATE | | 20c. LOCATION — City or Town, State OWINGS MILLS, MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death | | | |
| a. MYOCARDIAL INFARCTION, ACUTE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 50 mins. | | | |
| b. OCCLUSION, LEFT ANTERIOR DESCENDING CORONARY ARTERY DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Hours | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Michael E. Pelczar | | | | 29c. LICENSE NUMBER D09990 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Michael E. Pelczar St. Agnes Hospital 900 Caton Ave. Baltimore, Md 21229 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00308

| | | | | |
|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) William SILVER | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 9:45p M |
| 4. SOCIAL SECURITY NUMBER 216-01-0523 | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 79 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 7-15-1914 | 8. BIRTHPLACE (State or Foreign Country) MD |
| 9a. FACILITY NAME (If not institution, give street and number) CARROLL COUNTY GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER | | 9c. COUNTY OF DEATH CARROLL |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE MD | 10b. COUNTY BALTIMORE | 10c. CITY, TOWN OR LOCATION OWINGS MILLS | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 10e. STREET AND NUMBER 22 DEER LODGE CT. APT.E | | 10f. ZIP CODE 21117 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) SALESMAN | | 16. KIND OF BUSINESS/INDUSTRY CLEANING | | |
| 17. FATHER'S NAME (First, Middle, Last) BENJAMIN SILVER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA PLEET | | |
| 19a. INFORMANT'S NAME (Type/Print) DAVID SEIGER, ATTY. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 LIGHT ST. SUITE 510, BALTO, MD 21202 | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON-CHIZUK AMINO 1-6-1994 | | 20c. LOCATION — City or Town, State BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David Seiger</i> | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS, INC. 6010 REISTERSTOWN RD, BALTO, MD 21215 | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA b. EMPHYSEMA Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. d. | | | | Approximate Interval Between Onset and Death 10 DAYS 10 YRS. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William Silver</i> MD. | | 29c. LICENSE NUMBER D29264 | 29d. DATE SIGNED (Month, Day, Year) 1 4 94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 217 WASHINGTON HTS WESTMINSTER MD 21157 | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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SECRET

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SECRET

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00309 | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) JEROME H. STEIN | | | | 2. DATE OF DEATH MONTH 1 DAY 3 YEAR 94 | | | | 3. TIME OF DEATH 6:20 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-01-1370 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) MAY 4, 1915 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) LEVINDALE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 817 ST PAUL ST, APT. 301 | | | | 10f. ZIP CODE 21202 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ENGINEER | | 16b. KIND OF BUSINESS/INDUSTRY MANUFACTURER | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) LOUIS STEIN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FANNIE GOLDBERG | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS MELVA S. LISK | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7211 BROOK CREST WAY, APT. 2A BALTIMORE, MD 21208 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HEBREW ORTHODOX MEMORIAL SOCIETY-1-5-94 BALTIMORE, MD | | 20c. LOCATION — City or Town, State | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gay Alan Ferri</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → GANGRENE FEET WITH SEPTICEMIA Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST INSULIN DEPENDENT DIABETES MELLITUS SEVERE PERIPHERAL VASCULAR DISEASE | | | | Approximate Interval Between Onset and Death 3 MONTHS | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEVERE PERIPHERAL VASCULAR DISEASE | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Segevian</i> ATTENDING PHYSICIAN | | 29c. LICENSE NUMBER D 25610 | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LEVINDALE, 2434 W. BELVERDERE AVENUE, BALTIMORE MD 21215 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE <i>John S. ...</i> | | | | | | | | | | | |

A

ADP P. HNC

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00310

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Miles Sacks</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>4</i> YEAR <i>84</i> | | 3. TIME OF DEATH <i>1640</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>216-07-9936</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>79</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>1-12-1914</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>VIRGINIA</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>NORTHWEST HOSPITAL CENTER</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>RANDALLSTOWN</i> | |
| 9c. COUNTY OF DEATH <i>BALTIMORE</i> | | | | 10a. STATE <i>MD</i> | | | |
| 10b. COUNTY <i>BALTIMORE</i> | | | | 10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i> | | | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <i>7 SLADE AVENUE, APT. 410</i> | | | |
| 10f. ZIP CODE <i>21208</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>PROPRIETOR</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>HOME IMPROVEMENT</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>BARNEY H SACKS</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ANNIE CRAMER</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>MR. SIDNEY SACKS</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8 POMONA NORTH, APT. 8; BALTO, MD 21208</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>ARLINGTON-CHIZUK AMINO</i> | | 20c. LOCATION — City or Town, State <i>1-5-94 BALTIMORE, MD</i> | | 22. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD, BALTIMORE, MD 21215</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Cardiac shock</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. Ate by I</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER <i>H 43974</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1-4-94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director, page 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | REG. NO. | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Sigmund Spritz</i> | | | | 2. DATE OF DEATH MONTH <i>January</i> DAY <i>5</i> YEAR <i>1994</i> | | 3. TIME OF DEATH <i>4:08A M</i> | | | |
| 4. SOCIAL SECURITY NUMBER <i>340-24-1024</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>76</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>8/6/1917</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>SINAI HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i> | | | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10a. STATE <i>MARYLAND</i> | | 10b. COUNTY | | 10e. STREET AND NUMBER <i>3021 FALLSTAFF RD APT 206</i> | | 10f. ZIP CODE <i>21209</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <i>WWII</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <i>5+</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>OPTOMETRIST</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>MEDICAL</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>BENJAMIN SPRITZ</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>DINAH PEARLMAN</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>MRS DOROTHY SPRITZ</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3021 FALLSTAFF RD APT 206 BALTO MD 21209</i> | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>BALTIMORE HEBREW 1/7/94</i> | | DATE <i>1/7/94</i> | | 20c. LOCATION — City or Town, State <i>REISTERSTOWN MD</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jan Chan Lee</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <i>2 days</i> | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> <i>Coronary artery disease</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ali Niaz - House Officer</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>1/5/94</i> | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ALI NIAZ - Sinai Hospital - Baltimore</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

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Item 19b 1-21-94 Film G707 W.H. Per F/H

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00312

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DONALD GEORGE SCHISLER | | | | 2. DATE OF DEATH MONTH 01 DAY 03 YEAR 94 | | 3. TIME OF DEATH 10:05 A.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 217-16-4938 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Apr. 27 1923 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 3008 E. NORTHERN PARKWAY | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore City | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3008 E. Northern Parkway | | | | 10f. ZIP CODE 21214 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lt. Balt. City Fire Dept | | 15b. KIND OF BUSINESS/INDUSTRY Balt. City Gov't. | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) George F. Schisler | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Corinne C. Harrison | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Alan H. Stocksdales | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6717 Harford Road Baltimore, Maryland 21234 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 1/7/94 | | 20c. LOCATION — City or Town, State Baltimore Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Milton J. Knight Jr | | | | 22. NAME AND ADDRESS OF FACILITY Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Road | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute MD | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Anderson-Rodriguez | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00313

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES BENNETT SANDERS | | | | 2. DATE OF DEATH MONTH JAN DAY 05 YEAR 94 | | 3. TIME OF DEATH 1140A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-10-0276 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) October 9, 1909 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Randallstown | | | | 9c. COUNTY OF DEATH Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Pikesville | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 10 1/2 Old Court Road | | | | 10f. ZIP CODE 21208 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) College | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter | | 15b. KIND OF BUSINESS/INDUSTRY Local #101 | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Jacob Sanders | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice O'Conner | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. William J. Sanders | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 1/2 Old Court Road Pikesville, MD 21208 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 1/08/94 | | DATE 1/08/94 | | 20c. LOCATION — City or Town, State Pikesville Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, INC. 8728 Liberty Rd Randallstown, MD 21133-4784 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. COPD & LUNG CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death 4 DAYS. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PROSTATE CA; LUNG CA; CAD; CHF ATRIAL FIBRILLATION; RADIATION PNEUMONITIS | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER D37333 | | 29d. DATE SIGNED (Month, Day, Year) JAN 5, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. HAVI MD, NORTHWEST HOSP. CENTER, BALTO. MD 21133 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | |

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94 00314

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Della Gladys Smith | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 05 1994 | | 3. TIME OF DEATH 9:30 A. M | |
| 4. SOCIAL SECURITY NUMBER 214 24 0945 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 01/13/1923 | |
| 8. BIRTHPLACE (State or Foreign Country) West Virginia | | | | 9. COUNTY OF DEATH Cecil County | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Elkton | | 9c. COUNTY OF DEATH Cecil County | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford County | | 10c. CITY, TOWN OR LOCATION Joppa | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 301 Trimble Road Apt. 4 C | | | | 10f. ZIP CODE 21085 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 9th Grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Home Maker | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Adkins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Linda Johnson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Flying Point Road Edgewood, Maryland 21040 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Cedar Hill Cemetery | | DATE 1/7 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jerome Zimowski</i> | | | | 22. NAME AND ADDRESS OF FACILITY George J. Gonc Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Severe COPD | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas E. Finucan, Jr.</i> | | | | 29c. LICENSE NUMBER D32395 | | 29d. DATE SIGNED (Month, Day, Year) 1-5-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas E. Finucan, Jr., M.D. 3 Mauldin Avenue Northeast, Maryland 21901 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



3

Chapter 1. Introduction 1



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00315

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Sophie Schuck</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>5</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>2:14/5 P M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>216-28-9933</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>83</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>9-13-10</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>ST. AGNES HOSPITAL</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i> | | 9c. COUNTY OF DEATH ===== | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Baltimore County</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>3913 Myrtle Avenue</i> | | | | 10f. ZIP CODE <i>21227</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th Grade</i> College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Home Maker</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Stephen Chornyel</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Julia Chick</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Theresa Collison</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3913 Myrtle Avenue Baltimore, Maryland 21227</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <i>Cedar Hill Cemetery</i> | | DATE <i>1/8</i> | | 20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard E. Davis</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c. Atherosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i> | | | | | | Approximate Interval Between Onset and Death <i>7 days</i> <i>1 month</i> <i>year</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>None</i> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Francis J. Viorri</i> | | | | 29c. LICENSE NUMBER <i>D 35990</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/6/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>FRANCIS J. Viorri, M.D. 901 CADON AVE, Baltimore, Md. 2129</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>1/6/94</i> | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i> | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00316

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Leonard SCHREIBER | | | | 2. DATE OF DEATH MONTH DAY YEAR 1-4-94 | | 3. TIME OF DEATH 8:20 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 218-46-0193 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/13/05 | | 8. BIRTHPLACE (State or Foreign Country) Baltimore | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 31 Henry Ave. | | | | 10f. ZIP CODE 21236 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Fireman | | 16b. KIND OF BUSINESS/INDUSTRY Baltimore City | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Schreiber | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Emery | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Elma E. Link | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4121 Link Ave. Baltimore, Md. 21236 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 1/7/94 | | 20c. LOCATION — City or Town, State Baltimore, md. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lassahn Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypotension and bradycardia DUE TO (OR AS A CONSEQUENCE OF): b. Acute Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Baclor Karakash MD.</i> | | | | 29c. LICENSE NUMBER N/a | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Baclor Karakash 9000 Franklin Square Dr. Baltimore, Maryland 21237 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | | | |

21200 43

RECEIVED BY THE
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

APR 10 1964

APR 10 1964

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. | |
|---|--|--|--|---|--|---|--|
| 1. DECEDECENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | |
| SMITH Virginia S. Smith | | MONTH 1 DAY 5 YEAR 94 | | | | 4:15 A M | |
| 4. SOCIAL SECURITY NUMBER 245-03-7198 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-16-1913 | |
| 8. BIRTHPLACE (State or Foreign Country) Virginia | | 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Med. Ctr. | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH --- | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Eastpoint-Nt. Pt. | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7415 Belmont Avenue | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 15b. KIND OF BUSINESS/INDUSTRY Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Wallace Stafford | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Kennedy | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Helen Bower | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7415 Belmont Ave., Balto., Md. 21224 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GreenMount Crematory 1-7-94 Balto., Md. | | 20c. LOCATION — City or Town, State DATE | | 20d. LOCATION — City or Town, State 21222 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins D00083 | | 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc 2134 Willow Spring Rd., Balto., Md. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | a. OBSTRUCTIVE AIRWAYS DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): c. BRONCHOSPASM DUE TO (OR AS A CONSEQUENCE OF): d. | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29c. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29d. SIGNATURE AND TITLE OF CERTIFIER Way MD (WAY) INTERN | | 29e. LICENSE NUMBER 94016 | | 29f. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. WAY FRANCIS SCOTT KEY MEDICAL CENTER, BALTIMORE, MD 21224. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

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TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00318 | | | | | | | |
|--|--|--|---|---|--------------------------------|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) FLORENCE WALLACE | | | | 2. DATE OF DEATH JANUARY 8, 1994 | | 3. TIME OF DEATH 5:20A | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 219- 03- 0193 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 71 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 03- 11- 22 | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH n/a | | | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1832 N. CAROLINE STREET | | | | | | | | | |
| 10f. ZIP CODE 21213 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | | | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 TH | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LAB TECHNICIAN | | 15b. KIND OF BUSINESS/INDUSTRY JOHNS HOPKINS UNIVERSITY | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) EDGAR MONDOWNEY | | | | 18. MOTHER'S NAME (First Middle, Maiden Surname) LOTTIE FLEET | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) OLLEN W. DOUGLASS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3408 ESSEX ROAD, BALTIMORE, MARYLAND 21207 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | 20d. DATE 01-11 | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. Immunosuppressive Medication DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death 1 week | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Esophageal Rupture Aspiration Pneumonia | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER L8820 | | 29d. DATE SIGNED (Month, Day, Year) ▶ | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER BRAVERMAN John Hopkins Hospital Baltimore MD 21205 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | |

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00319

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Myrtle Nancy Wright | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 06, 1994 | | 3. TIME OF DEATH 11:30 A M | |
| 4. SOCIAL SECURITY NUMBER 233-46-0983 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09/06/31 | |
| 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Center/ER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH --- | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Dundalk | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 448 Trappe Road | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 15b. KIND OF BUSINESS/INDUSTRY Home | | | |
| 17. FATHER'S NAME (First, Middle, Last) Ottie Harvey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Monty | | | |
| 19a. INFORMANT'S NAME (Type/Print) Thomas D. Wright | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2125 Sunnyside Road Baltimore, MD 21220 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 1/10 | | 20c. LOCATION — City or Town, State Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb | | | | 22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., Inc. 299 Fredrick Road Baltimore, MD 21228 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Decompensated CHF Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Myocardial infarction c. d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Kiumarce Kashi | | | | 29c. LICENSE NUMBER Resident | | 29d. DATE SIGNED (Month, Day, Year) 01/07/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kiumarce Kashi, M.D. 9000 Franklin Square Drive Baltimore, MD 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been properly filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 28 is marked, or item 28 is marked, the medical examiner must be notified at once.

3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|---|--|---|--|----------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WARNER OSCAR D. Warner Sr. | | | | | | 2. DATE OF DEATH MONTH 01 DAY 07 YEAR 94 | | 3. TIME OF DEATH 1001A | | | |
| 4. SOCIAL SECURITY NUMBER 214-28-7401 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) January 7, 1994 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Westminster | | 9c. COUNTY OF DEATH Carroll | | | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION Westminster | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 857 Muller Road | | | |
| 10f. ZIP CODE 21157 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor | | 16b. KIND OF BUSINESS/INDUSTRY O & R Construction | | 17. FATHER'S NAME (First, Middle, Last) David A. Warner | | | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie B. Clingan | | 19a. INFORMANT'S NAME (Type/Print) Mrs. Helen Warner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 857 Muller Road Westminster, MD 21157 | | 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salem U.M. Church Cemetery 1/11/94 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY Burrier-Queen Funeral Directors, P.A. 21784 1212 West Old Liberty Road Winfield, MD | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) → Consecutive Heart failure Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Cancer of Prostate = Metastasis C. O. P. D. | | Approximate Interval Between Onset and Death | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER D39502 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SYED S. HOSAIN MD Carroll Co. Hosp. | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00321

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Houston G WAIDNER | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 8, 1994 | | 3. TIME OF DEATH 1:45 p.m. | | | | |
| 4. SOCIAL SECURITY NUMBER 215033575 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 80 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06/21/13 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH ROSSVILLE | | | 9c. COUNTY OF DEATH Baltimore County | | | |
| 10a. STATE MD | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 40 SURREY LANE | | | | 10f. ZIP CODE 21236 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MAINTENANCE | | 16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN F. WAIDNER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) INA BELL GEISBERT | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) EILEEN W. WAIDNER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 SURREY LANE BALTIMORE, MD 21236 | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | 20d. DATE 1/10 | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Myelodysplasia Emphysema | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Michael Kuo MD #0168 | | | | 29c. LICENSE NUMBER 0168 | | 29d. DATE SIGNED (Month, Day, Year) 1/8/94 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Kuo MD. 9000 Franklin Square Dr. Balto, Md. 21237 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM MARSHALL WAUGH | | | | 2. DATE OF DEATH MONTH DAY YEAR January 3 1994 | |
| 4. SOCIAL SECURITY NUMBER 577-18-2951 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 69 YRS. | 3. TIME OF DEATH 6:45 p. M | |
| 9a. FACILITY NAME (If not institution, give street and number) 1301 Chez Court | | 9b. CITY, TOWN OR LOCATION OF DEATH Fallston | | 9c. COUNTY OF DEATH Harford | |
| 10a. STATE Maryland | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Fallston | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 1301 Chez Court | | 10f. ZIP CODE 21047 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) 3 yrs. | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CPA | | 16b. KIND OF BUSINESS/INDUSTRY Waugh-Cross & Associates | | | |
| 17. FATHER'S NAME (First, Middle, Last) Thomas Emmet Waugh | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Snabely | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Jean S. Waugh | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 Chez Court Fallston, Maryland 21047 | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc. 1-6-94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>E. F. Lassahn</i> | | | 22. NAME AND ADDRESS OF FACILITY E. F. Lassahn Funeral Home 21087 11750 Belair Rd. Balto., Md. (Kingsville) | | |
| 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Melanoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated event resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Auerbach</i> | | 29c. LICENSE NUMBER D 33551 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Auerbach - Franklin Sq. Hospital 2nd Fl. (Dept. of Medicine) (682-7000) | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

94 00323

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Milton Wulk | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 4, 1994 | | | | 3. TIME OF DEATH 12:15 PM | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 064-14-6688 | | | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 13, 1918 | | 8. BIRTHPLACE (State or Foreign Country) New York | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 13216 Hathaway Drive | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Wheaton | | | | 9c. COUNTY OF DEATH Montgomery | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Montgomery | | | | 10c. CITY, TOWN OR LOCATION Wheaton | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 13216 Hathaway Drive | | | | | | | | 10f. ZIP CODE 20906 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4 | | | | | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner | | | | 16b. KIND OF BUSINESS/INDUSTRY Wulk Brother's | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Hyman W. Wulk | | | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Fine | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Irene Casanove | | | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13216 Hathaway Dr., Wheaton, Md. 20906 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Judean Memorial Garden 1/9 | | | | 20c. LOCATION — City or Town, State Olney, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John R. House</i> | | | | | | | | 22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Arlington, Virginia 22201 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ventricular Fibrillation | | | | | | | | | | | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John R. House</i> | | | | | | | | 29c. LICENSE NUMBER 1724819 | | | | 29d. DATE SIGNED (Month, Day, Year) 1-6-94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Zinsmeister, M.D. 8830 Cameron St., Suite 601, Silver Spring, Md. 20910 | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John R. House</i> | | | | | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00324

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) THOMAS J. YOKUBINAS | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 02, 1994 | | 3. TIME OF DEATH 0926 M | | | | | |
| 4. SOCIAL SECURITY NUMBER 219-32-7762 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 57 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) APRIL 14, 1936 | | 8. BIRTHPLACE (State or Foreign Country) PENN. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH PRINCE FREDERICK | | | | 9c. COUNTY OF DEATH CALVERT | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY CALVERT CO. | | 10c. CITY, TOWN OR LOCATION PRINCE FREDERICK | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 357 CACTUS TRAIL | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American-Indian, Black, White, etc. Specify: WHITE | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRONICS TECH. | | 16b. KIND OF BUSINESS/INDUSTRY BALD. GAS. + ELECTRIC | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN PAUL YOKUBINAS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA O. WRIGHT | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) ROBERT T. YOKUBINAS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7854 BIRMINGHAM AVE, PARKVILLE, MD. 21234 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH CEM. 1-6-94 | | DATE ROSEDALE, MD. | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeffrey L. Gail LIC.# MD0677 | | | | 22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE, MD. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death 3yrs. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26d. DESCRIBE HOW INJURY OCCURRED | |
| 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Charles Bennett M.D. | | | | | | 29c. LICENSE NUMBER D25156 | | 29d. DATE SIGNED (Month, Day, Year) January 3, 1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. BENNETT, M.D. PRINCE FREDERICK, MD 20678 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 13 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | CERTIFICATE OF DEATH | | REG. NO. 94 00325 | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Virginia Mae Allison Virginia Allison | | | | 2. DATE OF DEATH MONTH DAY YEAR 1-10-94 | | 3. TIME OF DEATH 4:40 AM | |
| 4. SOCIAL SECURITY NUMBER 212 20 9595 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 07 13 25 | |
| 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10a. STATE Md. | | | | 10b. COUNTY | | 10e. STREET AND NUMBER 2000 Odell Avenue Apt. 202 | |
| 10f. ZIP CODE 21237 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerical Work | | 17. KIND OF BUSINESS/INDUSTRY Savings & Loan | | | |
| 17. FATHER'S NAME (First, Middle, Last) ? Rembold | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Meada ? | | | |
| 19a. INFORMANT'S NAME (Type/Print) Howard L. Allison Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6416 Cammie Street Brooksville, Florida 3460 2 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory | | 20c. LOCATION — City or Town, State Balto., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles D. Zeiler | | 22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224 Eastern Avenue | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cyanosis from endstage COPD DUE TO (OR AS A CONSEQUENCE OF): b. heavy smoking history - morbid obesity asthma DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P MI x3 NIDDM | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29a. SIGNATURE AND TITLE OF CERTIFIER R. V. L. | | | | 29b. LICENSE NUMBER 94021 | | 29c. DATE SIGNED (Month, Day, Year) 1/10/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Deborah Josefson MD FSKHC Eastern Ave Balt | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE Fred Senior | | | |

28000 013

RECEIVED

NOV 14 1964

RECEIVED


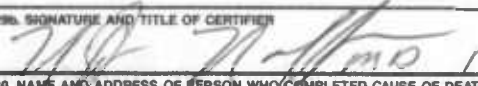
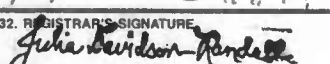
NOV 14 1964

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00326

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARILYN ADELSBERGER | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 10, 1994 | | 3. TIME OF DEATH 6:10 a.m. | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-30-0262 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 61 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 3, 1932 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | 9c. COUNTY OF DEATH ----- | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Kingsville | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | |
| 10e. STREET AND NUMBER 7002 Ruxford Drive | | | | 10f. ZIP CODE 21087 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (14 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Treasurer | | 16b. KIND OF BUSINESS/INDUSTRY Retail Sales | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Gooden Willis | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Ditman | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Paul D. Adelsberger (husband) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7002 Ruxford Drive, Kingsville, MD 21087 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem'l Gardens | | 20c. LOCATION — City or Town, State Timonium, MD | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Brain Tumor 6 AM 1/10/94 6 months DUE TO (OR AS A CONSEQUENCE OF): a. b. c. d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypothalamic dysfunction | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 1/10/94 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  J. I. Nark | | 29c. LICENSE NUMBER none | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) N. J. Nark J.M.H. Dept. of Neurosurgery | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00327

| | | | | | | | | | | | |
|---|--|--|--|---|---|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Hattie J. Boyer | | | | 2. DATE OF DEATH MONTH 1 DAY 7 YEAR 1994 | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-30-2138 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 58 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6-7-1935 | | 8. BIRTHPLACE (State or Foreign Country) Md | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2700 N. Charles | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE Md | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 4017 Woodhaven Avenue | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U S A | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | 16b. KIND OF BUSINESS/INDUSTRY Harbor Hospital Center | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Willie Highsmith | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Owens | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy Fullard | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4017 Woodhaven Avenue Baltimore, Md 21216 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park | | DATE 11294 | | 20c. LOCATION — City or Town, State Randallstown, Md | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thymis D. Scott | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Non small cell Carcinoma of lung Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Squamous cell metastasis c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death 1 yr | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Tubercal Esophageal fistula | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER John H. Copeland MD | | | | 29c. LICENSE NUMBER D27034 | | 29d. DATE SIGNED (Month, Day, Year) 110 94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John H. Copeland MD 5310 Old Court Road Suite 201 Randallstown MD 21133 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John H. Copeland | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00328

| | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Josephine H. Buckles | | | | 2. DATE OF DEATH MONTH DAY YEAR 5/10/94 94 855am | | | | 3. TIME OF DEATH 855am | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-40-0788 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 90 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 8-11-1903 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not Institution, give street and number) Union Memorial Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 621 EAST 37TH STREET | | | | | | 10f. ZIP CODE 21218 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8YRS. College (1-4 or 5+) _____ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | | | 16b. KIND OF BUSINESS/INDUSTRY HOMEMAKER | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) ANTHONY GUARINO | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CONCETTA RUSSO | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) GRACE M. GUARINO | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 EAST 37TH STREET BALTO., MD. 21218. | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOST HOLY REDEEMER 1/13 | | | | 20c. LOCATION — City or Town, State BALTO., MD. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE William R. Davis III | | | | | | 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intracerebral haemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. Myocardial infarct, antero-lateral DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate interval Between Onset and Death 4 hrs 18 hrs | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> _____ 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Katherine M. Cronin MD | | | | 29c. LICENSE NUMBER DEA AU 4176435 | | 29d. DATE SIGNED (Month, Day, Year) 10/1/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KMC Cronin MD 190 Union Memorial Hosp, Baltimore MD | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John Sanders | | | | | | | | | |

100-110000-1000

100-110000-1000

100-110000-1000

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00329 | |
|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Emma E. Butcher | | | | 2. DATE OF DEATH MONTH 1 DAY 7 YEAR 94 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 212-22-8587 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 7 6 19 | |
| 9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 968 North Hill Road | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (14 or 5+) 4 Years | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse | | 15b. KIND OF BUSINESS/INDUSTRY Mercy Hospital | | | |
| 17. FATHER'S NAME (First, Middle, Last) John R. Butcher | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Smith | | | |
| 19a. INFORMANT'S NAME (Type/Print) Edith Perry | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2218 Elsinore Avenue Baltimore, Maryland | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery | | DATE 1/12/94 | | 20c. LOCATION — City or Town, State Woodlawn, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Benny Harris | | | | 22. NAME AND ADDRESS OF FACILITY 1701 McCulloh St. Chatman-Harris F/H Baltimore, Md 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Bronchitis DUE TO (OR AS A CONSEQUENCE OF): d. COPD Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① Pulmonary embolism | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Chas. J. Harris MD | | | | 29c. LICENSE NUMBER D18847 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marlene J. Harris MD 844 N Carey St. 21217 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John S. Harris | | | |

Q121(0)54 1161 74 116

Q121(0)54 1161 74 116

Q121(0)54 1161 74 116



94-0056-510
DWG

94-002

94 00330

ITEMS: 23 PART I, II, 27, 28a, b, c, d, e, f PER MEO G-707 reb

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|----------------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DEBRA REGINA BERRY | | | | 2. DATE OF DEATH MONTH 01 DAY 03 YEAR 94 | | 3. TIME OF DEATH 11:15 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-64-2514 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 40 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06-12-53 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2300 BLOCK OF BOSTON | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | 9c. COUNTY OF DEATH n/a | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1813 N. WASHINGTON STREET | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED | | 16b. KIND OF BUSINESS/INDUSTRY n/a | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM BERRY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY Mc INTOSH | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) CAROLYN HARRIS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 E. LANVALE STREET, BALTIMORE, MARYLAND 21202 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY | | OATE 01-12 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. DROWNING DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC ALCOHOLISM | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) | | 26. PLACE OF DEATH (Check only one) 2300 BOSTON ARENA | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 1/3/94 | | 28b. TIME OF INJURY FOUND: 11:15 M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED SUBJECT DROWNED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) WATER | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2300 BOSTON ST. BOSTON ARENA, BALTIMORE, MD. | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/04/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 is marked, or item 28 is marked, the medical examiner must be notified at once.

94-0057-510

M.L.JR.

Item 1, g-707, 1-11-94, dr

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00331

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANNIE Bell BENNETT | | | | 2. DATE OF DEATH MONTH 01 DAY 03 YEAR 94 | | 3. TIME OF DEATH 5:06 P M | |
| 4. SOCIAL SECURITY NUMBER 217-12-9150 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11 25 12 | |
| 8. BIRTHPLACE (State or Foreign Country) S. Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number) 1018 N. BROADWAY | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH N/A | | | | 10a. STATE Maryland | | 10b. COUNTY N/A | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 1018 N. Broadway | |
| 10f. ZIP CODE 21205 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Factory worker | | 16b. KIND OF BUSINESS/INDUSTRY Unknown | |
| 17. FATHER'S NAME (First, Middle, Last) ? Hamilton | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Randolph Johnson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2227 E. Jefferson St. Baltimore, Maryland 21205 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery 1/14/94 | | 20c. LOCATION — City or Town, State Baltimore, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gray Harris</i> | | | | 22. NAME AND ADDRESS OF FACILITY 1701 McCulloh St. Chatman-Harris F/H Baltimore, Md 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Hypertensive Atherosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO <i>partial</i> 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Devin J. Chute</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/04/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Andrew Rusk</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 94 00332

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Richard P Burke-Sr | | | | 2. DATE OF DEATH MONTH 01 DAY 09 YEAR 94 | | 3. TIME OF DEATH 505 P M | |
| 4. SOCIAL SECURITY NUMBER 213-09-7315 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-8-1916 | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH ----- | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3544 Chestenfield Ave. | | | | 10f. ZIP CODE 21214 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant | | 16b. KIND OF BUSINESS/INDUSTRY Falcon Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward J. Bunke | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Redchurch | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Melanie M. Burke | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3544 Chestenfield Ave. Balto., Md. 21214 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem 11/18 Balto., Md | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE J. S. Small | | | | 22. NAME AND ADDRESS OF FACILITY Hartley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Subdural Hemorrhage Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Chronic Subdural Hematomas PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Heart Disease Diabetes Mellitus Hypertension 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Approximate Interval Between Onset and Death 5 days years | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 3 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Jacqueline Reynolds | | | | 29c. LICENSE NUMBER AT 2438946-F22 | | 29d. DATE SIGNED (Month, Day, Year) 1/9/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Union Memorial Hospital | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

5

IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature

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23

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00333

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Valeria Mae Boone | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 3 1994 | | 3. TIME OF DEATH 7:40 P.M. | |
| 4. SOCIAL SECURITY NUMBER 217-34-8886 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 57 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 4/9/1936 | | 8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD. | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH CITY | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 8 STONECROFT CT. | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: AFR. AMERICAN | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) ROWLAND ROLAND CORISH CORNISH | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) VIRGINIA MERRITT CORNISH | | | |
| 19a. INFORMANT'S NAME (Type/Print) PAMILA EASTMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8- STONECROFT CT, BALTIMORE, MARYLAND 21229 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST CEMETERY 1/11/94 | | 20c. LOCATION — City or Town, State OWINGS MILL, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL SER, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Septic Shock</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 120 240 Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M _____ | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D. Physician | | | | 29c. LICENSE NUMBER D43735 | | 29d. DATE SIGNED (Month, Day, Year) 1/13/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ERIK M JAMS, MD ST Agnes Hospital 600 Cedar Ave Baltimore, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

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cert. # 00334

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00335

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Martin Kevin Bradin | | | | 2. DATE OF DEATH MONTH 1 DAY 9 YEAR 94 | | 3. TIME OF DEATH 6:30 a.m. | |
| 4. SOCIAL SECURITY NUMBER 213-26-6347 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 63 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 1/24/1930 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) 3033 Westfield Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3033 Westfield Avenue | | | | 10f. ZIP CODE 21214 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrator | | 16b. KIND OF BUSINESS/INDUSTRY State of Maryland | | | |
| 17. FATHER'S NAME (First, Middle, Last) Matthew Martin Bradin | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Claire Fay Dempsey | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Mildred E. Bradin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3033 Westfield Avenue Baltimore, Md. 21214 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park Cemetery 1/12/94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | 20d. DATE 1/12/94 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna | | | | 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Acute Myocardial Infarction | | | | | |
| | | b. Atherosclerosis | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Francis Wiegman, M.D. | | | | 29c. LICENSE NUMBER D25569 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francis Wiegman, M.D. 8406 Harford Road Baltimore, Maryland 21234 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE Julius Anderson-Randall | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: The law requires that the death certificate be completed and filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR POSTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00336

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eva A. Bougourd | | | | 2. DATE OF DEATH MONTH DAY YEAR January 8, 1994 | | 3. TIME OF DEATH 4:15 A. M. | | | |
| 4. SOCIAL SECURITY NUMBER 215-16-7894 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) July 4, 1908 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Rossville | | | 9c. COUNTY OF DEATH Baltimore | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 25 Torque Way | | | | 10f. ZIP CODE 21220 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade | | 15b. COLLEGE (1-4 or 5+) College (1-4 or 5+) | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker | | | 16b. KIND OF BUSINESS/INDUSTRY Home | | |
| 17. FATHER'S NAME (First, Middle, Last) Rumuly | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Bernadine E. Mitchell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Pine Road Joppa, Maryland-21085 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 1-11 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen M. Murphy | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road Baltimore, Md.-21206 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute CVA & Come Possible MI Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ↑ BP. D. Hells. Myocardial c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER T. A. H. Hower | | | | 29c. LICENSE NUMBER D14221 | | 29d. DATE SIGNED (Month, Day, Year) 1. 10. 94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. A. H. Hower, 223 B. Blvd. BALT MD 21221 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | |

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00337

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT MERLIN BRYANT | | | | 2. DATE OF DEATH MONTH 1 DAY 8 YEAR 94 | | 3. TIME OF DEATH 15:58 M | |
| 4. SOCIAL SECURITY NUMBER 312-18-8381 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12.16.21 | |
| 9a. FACILITY NAME (If not institution, give street and number) SR FALLSTON GEN HOSP | | 9b. CITY, TOWN OR LOCATION OF DEATH FALLSTON MD | | 9c. COUNTY OF DEATH HARFORD | | 8. BIRTHPLACE (State or Foreign Country) West Va. | |
| 10a. STATE DE | | 10b. COUNTY WASHINGTON | | 10c. CITY, TOWN OR LOCATION DISTRICT OF COLUMBIA WASHINGTON | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 3605 PATTERSON ST, N.W. | | | | 10f. ZIP CODE 20015 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 Years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Senior Draftsman | | 16b. KIND OF BUSINESS/INDUSTRY Planning Department City of Baltimore | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles Ernest Bryant | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Hinchman | | | |
| 19a. INFORMANT'S NAME (Type/Print) Aditha H. Bryant | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3605 Patterson Street, N.W., Washington, D.C. 20015 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 1/12/94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc., 6415 Belair Road, Baltimore, Maryland 21206 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. AC CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. ASWD DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 1 hr |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CA Lung R Pneumothorax | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) NA | | 28b. TIME OF INJURY NA | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA | | 28e. DESCRIBE HOW INJURY OCCURRED NA | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER DME | | | | 29c. LICENSE NUMBER D 21809 | | 29d. DATE SIGNED (Month, Day, Year) 1-8-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. PRASHU 1810 BELAIR MD FALLSTON MD 21047. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Vertical text on the left margin, possibly a page number or identifier.

Horizontal line with an arrow pointing right, possibly a title or section header.

(A)

Horizontal line with text below it, possibly a signature or date.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00338

| | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles Robert Bannan, Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR January 6, 1994 | | | | 3. TIME OF DEATH 6:07 P. M. | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 192-14-8537 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) March 3, 1925 | | 8. BIRTHPLACE (State or Foreign Country) Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 6531 Hilltop Avenue | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | | 9c. COUNTY OF DEATH N/A | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore City | | | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 6531 Hilltop Avenue | | | | | | 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Parts Man | | | | 16b. KIND OF BUSINESS/INDUSTRY Bob Bell Ford | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Bannan | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Saviere | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Irene M. Bannan | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6531 Hilltop Avenue, Baltimore, Maryland 21206 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer Cemetery 1/8/94 | | | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen M. Murphy</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cancer of bile ducts</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>peritoneal metastases, ascitis</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Cardio pulmonary failure</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate interval Between Onset and Death 6 months | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ms. S. Dolhar</i> | | | | | | 29c. LICENSE NUMBER D22105 | | 29d. DATE SIGNED (Month, Day, Year) January 6, 1994 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Mukund S. Didolkar, 2401 W. Belvedere Avenue, Baltimore, Maryland 21215 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00339

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|---|-------------|---|--|--|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Dennis Crosby | | | | 2. DATE OF DEATH MONTH 1 DAY 6 YEAR 1994 | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER 219-18-3200 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6-17-1926 | | 8. BIRTHPLACE (State or Foreign Country) Arkansas | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2420 Arunah Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE Md | | | 10b. COUNTY | | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 2420 Arunah Avenue | | | | 10f. ZIP CODE 21216 | | | | 10g. CITIZEN OF WHAT COUNTRY? U S A | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Will Crosby | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Easter Harvey | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Frances Crosby | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2420 Arunah Avenue Baltimore, Md 21216 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | | OATE 11294 | | 20c. LOCATION — City or Town, State Baltimore, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gala March | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death 1 month | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Endstage Renal Disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Neil R. Powe MD | | | | | | 29c. LICENSE NUMBER D33523 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Neil R. Powe MD The Johns Hopkins Hospital, Carnegie 284 Baltimore MD 21287 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John Anderson-Rodell | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00340

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ethel Chenowith | | | | 2. DATE OF DEATH - 5-94 MONTH DAY YEAR Jan 5 1994 | | | | 3. TIME OF DEATH 7:30 P.M. | |
| 4. SOCIAL SECURITY NUMBER 219 34 6769 | | 5. SEX F | | 6. AGE (In yrs. last birthday) 56 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-27-1937 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH na | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY na | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER 22 Athol Street/IrvingtonKnollN/H | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 2 Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES NO | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) NO | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY Homemaker | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John King | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Myrtle | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) William Chenowith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joppa Rd, Baltimore, MD | | | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Subarachnoid Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): Hydrocephalus DUE TO (OR AS A CONSEQUENCE OF): Gastrointestinal Bleeding DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Diabetes Mellitus Cerebrovascular Accident | | | | | | | | Approximate Interval Between Onset and Death 1 week | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Cerebrovascular Accident | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | |
| 27. MANNER OF DEATH 1 Natural 6 Pending Investigation 2 Accident 7 Could not be determined 3 Suicide 8 Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER George E. Wicks III | | 29c. LICENSE NUMBER 041365 | | 29d. DATE SIGNED (Month, Day, Year) Jan 5, 1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George E. Wicks III 2600 Liberty Heights | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John D. Anderson | | | | | |

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[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00341

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>LEE CAMERON</u> | | 2. DATE OF DEATH MONTH <u>1</u> DAY <u>6</u> YEAR <u>1994</u> | | 3. TIME OF DEATH <u>10:10 AM</u> | |
| 4. SOCIAL SECURITY NUMBER <u>218 14 5522</u> | | 5. SEX <u>1</u> M <u>2</u> F | | 6. AGE (In yrs. last birthday) <u>86</u> YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) <u>8-31-1907</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u> | | 9. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u> | |
| 10. FACILITY NAME (If not institution, give street and number) <u>Sinai Hospital</u> | | 11. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u> | | 12. COUNTY OF DEATH <u>na</u> | |
| 13. STATE <u>Maryland</u> | | 14. COUNTY <u>na</u> | | 15. CITY, TOWN OR LOCATION <u>Baltimore</u> | |
| 16. STREET AND NUMBER <u>2434 W. Belvedere Avenue</u> | | 17. ZIP CODE <u>21215</u> | | 18. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 19. MARITAL STATUS <u>3</u> Widowed <u>4</u> Divorced | | 20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> YES <u>2</u> NO IF YES, GIVE WAR OR DATES <u>no</u> | | 21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> YES <u>2</u> NO Specify: <u>White</u> | |
| 22. DECEASED'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> | | 23. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Merchandise</u> | | 24. KIND OF BUSINESS/INDUSTRY <u>Merchandise</u> | |
| 25. FATHER'S NAME (First, Middle, Last) <u>Charles Cameron</u> | | 26. MOTHER'S NAME (First, Middle, Maiden Surname) <u>-</u> | | 27. INFORMANT'S NAME (Type/Print) <u>Richard Cameron</u> | |
| 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2322 S. Arlington Ridge Rd, Arlington VA 22202</u> | | 29. METHOD OF DISPOSITION <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify) <u>-</u> | | 30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>-</u> | |
| 31. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Ronald Wade, Dir</u> | | 32. NAME AND ADDRESS OF FACILITY <u>State Anatomy Board</u> <u>655 W. Baltimore St, Balto, MD 21201</u> | | 33. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardiogenic shock</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>myocardial infarction</u> | |
| 34. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renal Failure</u> | | 35. WAS AN AUTOPSY PERFORMED? <u>1</u> YES <u>2</u> NO <u>CSM</u> | | 36. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <u>1</u> YES <u>2</u> NO | |
| 37. WAS CASE REFERRED TO MEDICAL EXAMINER? <u>1</u> YES <u>2</u> NO | | 38. PLACE OF DEATH (Check only one) HOSPITAL: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA OTHER: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) <u>-</u> | | 39. MANNER OF DEATH <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>7</u> Homicide <u>4</u> Homicide | |
| 40. DATE OF INJURY (Month, Day, Year) <u>-</u> | | 41. TIME OF INJURY <u>M</u> | | 42. INJURY AT WORK? <u>1</u> YES <u>2</u> NO | |
| 43. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>-</u> | | 44. DESCRIBE HOW INJURY OCCURRED <u>-</u> | | 45. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>-</u> | |
| 46. CERTIFIER (Check only one) <u>1</u> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 47. SIGNATURE AND TITLE OF CERTIFIER <u>James C. Heron</u> | | 48. LICENSE NUMBER <u>-</u> | |
| 49. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>James C. Heron Sinai Hospital of Baltimore</u> | | 50. DATE FILED (Month, Day, Year) <u>JAN 11 1994</u> | | 51. REGISTRAR'S SIGNATURE <u>John R. Anderson</u> | |

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NOT FINAL

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00342

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES FREDERICK CERNIK | | | | 2. DATE OF DEATH MONTH 11 DAY 10 YEAR 94 | | 3. TIME OF DEATH 7:44 A M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-12-1477 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/11/19 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) FALLSTON GENERAL HOSP. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH FALLSTON | | | | 9c. COUNTY OF DEATH HARFORD | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION White Hall | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 3017 Duncan Road | | | | 10f. ZIP CODE 21161 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stevedore | | 16b. KIND OF BUSINESS/INDUSTRY Cargo Co. | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) James Anthony Cernik | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Gelzer | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ruth A. Cernik (wife) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3017 Duncan Rd., White Hall, MD 21161 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gar. 1/13 Timonium, MD | | 20c. LOCATION — City or Town, State | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Abdominal Aortic Aneurysm b. Hypertensive Arteriosclerotic Cardiovascular Dis. c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER D23450 | | 29d. DATE SIGNED (Month, Day, Year) 1/11/94 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Walter Hepner, III, 3313 Paper Mill Rd., Phoenix, MD 21131 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | |

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OFFICE OF THE
DIRECTOR OF THE
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1900

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00343

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) THION <i>Rodriguez</i> CARR <i>JR.</i> | | | | 2. DATE OF DEATH MONTH <i>01</i> DAY <i>04</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>5:50</i> P M | |
| 4. SOCIAL SECURITY NUMBER <i>213-92-1379</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>15</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>7-9-78</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>900 BLOCK OF VALLEY STREET</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i> | | 9c. COUNTY OF DEATH <i>md</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>md</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>BALTO.</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>1600 CLIFVIEW AVE</i> | | | | 10f. ZIP CODE <i>21213</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Student</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Thion R. Carr Sr.</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Valarie Jenkins</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Valarie Jenkins</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1600 CLIFVIEW AVE BALTO MD 21213</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Lawrence</i> <i>1/2</i> | | 20c. LOCATION — City or Town, State <i>BALTO. MD</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Betts Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>1129 N. Caroline</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Multiple Gunshot Wounds</i> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>STREET</i> | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) <i>01/04/94</i> | | 28b. TIME OF INJURY <i>5:49P</i> M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>STREET</i> | | 28e. DESCRIBE HOW INJURY OCCURRED <i>SUBJECT WAS SHOT</i> | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>900 BLOCK OF VALLEY STREET</i> | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rawn Locke MD</i> | | | | 29c. LICENSE NUMBER <i>O.C.M.E.</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>01/05/1994</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>J. LARON Locke MD 111 Penn Street, Baltimore, Maryland 21201</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 11 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>John S. ...</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY ELIZABETH CHERRY | | | 2. DATE OF DEATH MONTH 1 DAY 8 YEAR 1994 | | 3. TIME OF DEATH 6:45 PM |
| 4. SOCIAL SECURITY NUMBER 215- 14- 4168 | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 73 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 5 12 20 | 8. BIRTHPLACE (State or Foreign Country) Balto. Md. | |
| 9a. FACILITY NAME (If not institution, give street and number) Liberty Med. Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, MD | | 9c. COUNTY OF DEATH n/a | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE Maryland | 10b. COUNTY n/a | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 717 Druid Lake Park Dr. | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 TH College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic | | 16b. KIND OF BUSINESS/INDUSTRY n/a | |
| 17. FATHER'S NAME (First, Middle, Last) Samuel Stone | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Mae Pryor | | |
| 19a. INFORMANT'S NAME (Type/Print) Catherine Tucker | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 E. 30th Street Baltimore, Maryland | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WISSELL MEMORIAL GARDEN | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY William C. Brown Community 1101 E. NORTH AVE. WILLIAM C. MARCH 1206 W. North Ave. Balto. Md. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA OF LUNG DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Attorn Physician | | | 29c. LICENSE NUMBER D 42723 | | 29d. DATE SIGNED (Month, Day, Year) 1/8/94 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AVERA HALL M HARISH 3745 FOXFORD STREAM RD MD 21236 | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours and death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is checked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20 0037

20 0037

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00345

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>George S. Collins</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>3</i> YEAR <i>94</i> | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>239-46-1236</i> | | 5. SEX <i>Male</i> | | 6. AGE (In yrs. last birthday) <i>58</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>7-4-35</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>N.C.</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>930 N. Mount St</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i> | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE <i>Maryland</i> | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <i>3915 Maine Ave</i> | | | | 10f. ZIP CODE <i>21207</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Cab Driver</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Thomas Collins</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bertha Dudley</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Doris Collins</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3915 Maine Ave. Baltimore Md. 21207</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Druid Lake Cem</i> | | DATE <i>1/8</i> | | 20c. LOCATION — City or Town, State <i>BALTO. Co. Md.</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Reuss</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Joseph L. Reuss Funeral Home 2322 W. North Ave. Balto. Md. 21216</i> | | | | | | | |
| 23. PART I. Enter the disease(s), or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>LIVER CANCER, SECONDARY; UNKNOWN PRIMARY</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theresa Anne</i> | | | | 29c. LICENSE NUMBER <i>D29071</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1-10-94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>R. KRISHNAN MD 821 N. EUTAW ST #305 BALTIMORE MD 21201</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 11 1994</i> | | | | | | | | | | | |

94 00346

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) John Joseph Chies, Jr. | | | | 2. DATE OF DEATH January 5, 1994 | | 3. TIME OF DEATH 4:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER 212-26-9844 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 65 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/20/1928 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 4702 Pennington Ave., 21226 | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore (Curtis Bay) | | 9c. COUNTY OF DEATH NA | |
| 10a. STATE Maryland | | | | 10b. COUNTY NA | | 10c. CITY, TOWN OR LOCATION Baltimore (Curtis Bay) | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 4703 Pennington Avenue, | | | | 10f. ZIP CODE 21226 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Navy | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Factory Worker | | 16b. KIND OF BUSINESS/INDUSTRY General Electric (Locke Insulator) | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Joseph Chies (Cheicis) Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Dotson Chies | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. William L. Chies | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 260 Scotts Manor Drive, Glen Burnie, Md. 21061 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery 1/8/94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Renal Failure | | | | | | | |
| b. Rectal Carcinoma With Obstruction to Ureters | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Painless Myocardial Infarction | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Richard E. Fisher, M.D. | | | | 29c. LICENSE NUMBER D02519 | | 29d. DATE SIGNED (Month, Day, Year) 6-Jan-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Richard E. Fisher, M.D. 4710 Pennington Ave., Baltimore, Maryland 21226 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00347

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Virgie Cunningham</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>1-8-94</i> | | 3. TIME OF DEATH H M <i>1:50</i> | |
| 4. SOCIAL SECURITY NUMBER <i>212-40-7298</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>86</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>Jan. 15, 1907</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>EGH Fallston General Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>FALLSTON</i> | | 9c. COUNTY OF DEATH <i>H/I Harford</i> | |
| 10a. STATE <i>Md.</i> | | 10b. COUNTY <i>Harford</i> | | 10c. CITY, TOWN OR LOCATION <i>Edgewood</i> | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>2013 Bayberry Road</i> | | | | 10f. ZIP CODE <i>21040</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i> | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Omer Wilson</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Esma Fitzwater</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mabel Mullins</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2013 Bayberry Road Edgewood Md. 21040</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Holly Hill Cemetery 1/10/94 Baltimore MD.</i> | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Connelly Funeral Home of Essex 300 Mace Ave Baltimore MD. 21221</i> | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>acute pulmonary edema / respiratory arrest</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <i>probable acute myocardial infarction</i> c. <i>Sepsis</i> d. <i>Carcinoma</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Phenicious anemia</i> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY H M <i>1</i> <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Patricia A. Weber MD</i> | | | | 29c. LICENSE NUMBER <i>D31704</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/8/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>PATRICIA A. WEBER MD.</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00348

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Genevieve C. Creamer</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>4</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>1:45 P M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>217-07-2720</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>74</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>12/8/19</i> | |
| 8. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key Hospital</i> | | | | 9. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 10. COUNTY OF DEATH <i>Baltimore</i> | |
| 11. RESIDENCE OF DECEDENT | | | | 12. STATE <i>MD</i> | | 13. COUNTY <i>Baltimore</i> | |
| 14. STREET AND NUMBER <i>802 S. Patomac St</i> | | | | 15. ZIP CODE <i>21224</i> | | 16. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 17. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 20. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th</i> College (1-4 or 5+) <i>—</i> | | 22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOUSEWIFE</i> | | 23. KIND OF BUSINESS/INDUSTRY <i>—</i> | | | |
| 24. FATHER'S NAME (First, Middle, Last) <i>FRANCIS HALL</i> | | | | 25. MOTHER'S NAME (First, Middle, Maiden Surname) <i>SALLY PIASECKI</i> | | | |
| 26. INFORMANT'S NAME (Type/Print) <i>MRS. JANET CHESTER</i> | | | | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2806 2nd Street, Baltimore, MD 21219</i> | | | |
| 28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>SACRED HEART OF JESUS CH 1-7</i> | | 30. DATE <i>1-7</i> | | 31. LOCATION — City or Town, State <i>BALTIMORE, MD.</i> | |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ann S. Matthews</i> | | | | 33. NAME AND ADDRESS OF FACILITY <i>MATTHEWS FUNERAL HOME 3021 Eastern Ave., Baltimore, MD 21224</i> | | | |
| 34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Rupture/leak of abdominal aortic aneurysm</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. — DUE TO (OR AS A CONSEQUENCE OF):</i> <i>c. — DUE TO (OR AS A CONSEQUENCE OF):</i> <i>d. —</i> | | | | | | 35. Approximate Interval Between Onset and Death <i>26 hours</i> | |
| 36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>multi system organ failure</i> | | | | | | 37. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 38. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 39. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 40. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 41. 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 42. 28a. DATE OF INJURY (Month, Day, Year) | | 43. 28b. TIME OF INJURY <i>M</i> | |
| 44. 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 45. 28d. DESCRIBE HOW INJURY OCCURRED | | 46. 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 47. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 48. 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 49. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph A. Calhoun MD</i> | | | | 50. 29c. LICENSE NUMBER <i>9A053</i> | | 51. 29d. DATE SIGNED (Month, Day, Year) <i>1/4/94</i> | |
| 52. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Joseph A. Calhoun MD</i> | | | | | | | |
| 53. 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

34800 #2

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00349 | |
|--|--|---|--|---|--|----------|--|
| | | CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. DECEDENT'S NAME (First, Middle, Last) Samuel B. Deadwyler, Jr. | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 94 | | 3. TIME OF DEATH 5:35 P M | | | |
| 4. SOCIAL SECURITY NUMBER 220-22-2993 | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 64 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 7-26-1929 | 8. BIRTHPLACE (State or Foreign Country) Va | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Md General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | 10a. STATE Md | | 10b. COUNTY | | | |
| 10c. CITY, TOWN OR LOCATION Balto | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 3234 Normount Ave | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc. Specify: Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | |
| 16b. KIND OF BUSINESS/INDUSTRY U.S. Post office | | 17. FATHER'S NAME (First, Middle, Last) Samuel B. Deadwyler, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Johnson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Marian R. Deadwyler | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3234 Normount Ave Balto, Md 21216 | | 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Uet 1/10/94 | | 20c. LOCATION — City or Town, State Owings Mills, Md | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Blennis B. Scott | | | |
| 22. NAME AND ADDRESS OF FACILITY March F.H. West 4300 Wabash Ave Balto, Md 21215 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident secondary to Cerebral infarct DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER J. O. Byrne MD | | 29c. LICENSE NUMBER 89205 | | | |
| 29d. DATE SIGNED (Month, Day, Year) 1/19/94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | |
| 32. REGISTRAR'S SIGNATURE Julia Anderson-Rodriguez | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00350 | | | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Louise Elizabeth DEGRAFF | | | | 2. DATE OF DEATH MONTH DAY YEAR January 8, 1994 | | | | 3. TIME OF DEATH 6:10 p M | | | | | |
| 4. SOCIAL SECURITY NUMBER 577-18-8323 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 21, 1918 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH Baltimore County | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 4239 Darleigh Road | | | | 10f. ZIP CODE 21236 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (14 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office Manager | | 16b. KIND OF BUSINESS/INDUSTRY Dredging Co. | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Herman Wertheimer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Louise Gunther | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Charles L. Tarbutton, Jr. (son) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8321 Woodland Road, Pasadena, MD 21122 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory | | DATE | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Michael Kuo MD / Kuo #0168 | | | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/8/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kuo, Michael MD #0168 9000 Franklin Square Drive, Baltimore, Maryland 21237 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson | | | | | | | | | |

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

[Handwritten signature] APR 1 1961

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DETZEL DORIS Doris L. Detzel | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 07 94 | | 3. TIME OF DEATH 12:54 M | |
| 4. SOCIAL SECURITY NUMBER 216-20-9172 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 76 YRS. | IF UNDER 1 YEAR MONTHS DAYS 1 14 | | IF UNDER 24 HRS. HOURS MIN. 19 17 | |
| 7. DATE OF BIRTH (Month, Day, Year) 1/14/1917 | | | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9. COUNTY OF DEATH Baltimore | |
| 9a. FACILITY NAME (If not institution, give street and number) Mary medical center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore Maryland | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY ----- | | 10c. CITY, TOWN OR LOCATION Balto. City, Md. | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1114 Battery Ave. | | 10f. ZIP CODE 21230 | |
| 10g. CITIZEN OF WHAT COUNTRY? United States | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade College (1-4 or 5+) None | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | 17. FATHER'S NAME (First, Middle, Last) George W. Miles | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Johnson | | | | 19a. INFORMANT'S NAME (Type/Print) Doris Jones | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1512 Clarkson St. Balto. Md. 21230 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Park 1/10/94 | | 20c. LOCATION — City or Town, State Glen Burnie, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE David A. Taylor | | | | 22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. respiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. bronchogenic carcinoma (metastatic) c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined 27a. DATE OF INJURY (Month, Day, Year) 27b. TIME OF INJURY 27c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 27d. DESCRIBE HOW INJURY OCCURRED 27e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 27f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. SIGNATURE AND TITLE OF CERTIFIER Edmond MD 29b. LICENSE NUMBER 17123 29c. DATE SIGNED (Month, Day, Year) 1/7/94 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) JAN 10 1994 | |

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00352

| | | | | | | |
|--|--|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM LEE DUNEVANT | | | 2. DATE OF DEATH MONTH DAY YEAR January 7, 1994 | | 3. TIME OF DEATH 1220 M | |
| 4. SOCIAL SECURITY NUMBER 214-48-0380 | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 46 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 11/07/47 | 8. BIRTHPLACE (State or Foreign Country) MISSOURI | | |
| 9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY | | 9c. COUNTY OF DEATH WICOMICO | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE MARYLAND | 10b. COUNTY WICOMICO | | 10c. CITY, TOWN OR LOCATION SALISBURY | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 403 LINCOLN AVENUE | | | 10f. ZIP CODE 21801 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CORRECTIONAL OFFICER | | 16b. KIND OF BUSINESS/INDUSTRY MARYLAND STATE CORRECTION | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM M. DUNEVANT | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GLORIA BYNUM | | | |
| 19a. INFORMANT'S NAME (Type/Print) GARY MICHAEL DUNEVANT | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 814 E. 35th STREET, BALTIMORE, MD 21218 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD. VETERANS CEMETERY | | DATE 1994 | 20c. LOCATION — City or Town, State CROWNSVILLE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>metastatic colon cancer</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | Approximate Interval Between Onset and Death 3 yrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. SIGNATURE AND TITLE OF CERTIFIER C. Haggman MD | | | |
| 29c. LICENSE NUMBER D25219 | | | 29d. DATE SIGNED (Month, Day, Year) 1-7-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLIE STEGMAN 30434 MT. VERNON RD. PRINCESS ANNE MD 21853 | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | 32. REGISTRAR'S SIGNATURE Julia Anderson-Rodriguez | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The registrar requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 94 00353 | | | | | |
|--|--|--|--|--|---|---|--|--|-----------------------------------|---|--|--------------------------------------|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) GEORGIA ANNA EASTON | | | | | 2. DATE OF DEATH MONTH DAY YEAR January 7, 1994 | | | 3. TIME OF DEATH 6:58 A M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-20-1859 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-2-1909 | | 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring | | | 9c. COUNTY OF DEATH Montgomery | | | | | | | |
| 10a. STATE Maryland | | | | | 10b. COUNTY Montgomery | | 10c. CITY, TOWN OR LOCATION Silver Spring | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 4 Tiffany Court | | | | | 10f. ZIP CODE 20904 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE - American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | 16b. KIND OF BUSINESS/INDUSTRY Home | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Fox | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Williams | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ruth E. Day | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Tiffany Court Silver Spring, MD 20904 | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 1-10 Baltimore, Maryland | | | 20c. LOCATION - City or Town, State Baltimore, Maryland | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | | 22. NAME AND ADDRESS OF FACILITY Black Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707 | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | |
| | | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c. LICENSE NUMBER D14440 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TERESA J. SCHNAPP MD 1161 New Hampshire Avenue Silver Spring MD 20904 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | | |

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00354

| | | | | | | | |
|--|--|--|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) James Henry Edwards | | | | 2. DATE OF DEATH MONTH 1 DAY 8 YEAR 94 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 216-07-1907 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 76 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 10 26 17 | 8. BIRTHPLACE (State or Foreign Country) N. Carolina | | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1111 Park Avenue #404 | | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW2 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) 4 Years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Food Inspector | | 16b. KIND OF BUSINESS/INDUSTRY Baltimore City Health Department | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Edwards | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna White | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dianna E. Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6119 Benhurst Road Baltimore, Maryland 21209 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) State Anatomy Board | | DATE | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gray Harris</i> | | | | 22. NAME AND ADDRESS OF FACILITY 1701 McCulloh St. Chatman-Harris F/H Baltimore, Md 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → b CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF): a MALIGNANT VENTRICULAR ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): c CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Edwards MD</i> | | | | 29c. LICENSE NUMBER 1303209 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH N. Kwan, 821 N. Eutan St Suite 311, Balt, Md 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Edwards</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Thomas H. Eminizer | | | | 2. DATE OF DEATH MONTH 1 DAY 4 YEAR 1994 | | 3. TIME OF DEATH 1255 M | |
| 4. SOCIAL SECURITY NUMBER 214-24-9271 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2/17/1929 | |
| 9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH NA | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Baltimore (Brooklyn Park) | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 515 Taney Avenue, | | | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW 2 Navy | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Administrator | | 16b. KIND OF BUSINESS/INDUSTRY Balto. Co. Health Dept. | |
| 17. FATHER'S NAME (First, Middle, Last) Ira Eminizer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Juanita Heil Eminizer Bloom | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Norma Eminizer | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Taney Ave., Baltimore, Maryland 21225 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 1/7/94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Acute Cardio-pulmonary Arrest | | | | | Approximate Interval Between Onset and Death Immediate |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Acute Respiratory Insufficiency | | | | | 2 days |
| | | c. Staphylococcal Pneumonia | | | | | one month |
| | | d. | | | | | |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Normal Pressure Hydrocephalus Insulin-Dependent Diabetes | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Colvin Carter | | | | 29c. LICENSE NUMBER D01459 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Colvin Carter, M.D. 4710 Pennington Ave Balto., Md. 21226 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is completed, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00356 | | | |
|---|--|--|--|---|--------------------------------|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Eula Wynnell Flack</u> | | | | 2. DATE OF DEATH MONTH DAY YEAR <u>January 8, 1994</u> | | 3. TIME OF DEATH <u>11 A M</u> | | | | | |
| 4. SOCIAL SECURITY NUMBER <u>421-48-3151</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <u>63</u> YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) <u>10-26-30</u> | | 8. BIRTHPLACE (State or Foreign Country) <u>Alabama</u> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Beltsville Elderly Care Home</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Beltsville</u> | | 9c. COUNTY OF DEATH <u>Prince George</u> | | | | | |
| 10a. STATE <u>Alabama</u> | | 10b. COUNTY <u>Morgan</u> | | 10c. CITY, TOWN OR LOCATION <u>Summerville</u> | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER <u>Route 3 Box 706</u> | | | | 10f. ZIP CODE <u>35670</u> | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>2</u> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Inventory Mgt. Specialist</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>US Gov't</u> | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Charles Dean</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Emma Breeding</u> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>James D. Flack</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6806 Dunnigan Drive Clinton, MD 20735</u> | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>West Point Baptist Church Cem.</u> | | OATE | | 20c. LOCATION — City or Town, State <u>Summerville, Alabama</u> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Kalace J. Flack</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Fleck Funeral Home, Inc.</u> <u>7601 Sandy Spring Road Laurel, MD 20707</u> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>SEPTICAEMIA</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. <u>ACUTE LEUKAEMIA</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>S/P BYPASS; HT, CHRONIC RENAL FAILURE, SENILE DEMENTIA</u> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Chloe MD</u> | | | | 29c. LICENSE NUMBER <u>D22755</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>1. 9. 94</u> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>7120 CONTEE RD, # 260 LAUREL MD 20707 (CHRISTINE DELIMA MD)</u> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 11 1994</u> | | | | 32. REGISTRAR'S SIGNATURE <u>Jada Benison-Randall</u> | | | | | | | |

94 00357

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--------------------------------|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) CLINTON FRAZIER | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 3, 1994 | | 3. TIME OF DEATH 10:20 p. M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY na | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2818 E. Jefferson Street | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Asthma Exacerbation DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death years |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Gregory Wm Branch, MD | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gregory Wm Branch JHH 600 N Wolfe Street Baltimore 21287 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John Anderson-Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12345 67

2

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00358


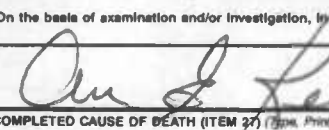

| | | | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|-----------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BYRNA JUNE FIERSTEIN | | | | 2. DATE OF DEATH MONTH DAY YEAR 01-02-1994 | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-32-7996 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-20-1915 | | 8. BIRTHPLACE (State or Foreign Country) Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Howard County General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Columbia | | | 9c. COUNTY OF DEATH Howard County | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Howard County | | 10c. CITY, TOWN OR LOCATION Clarksville | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 6125 Tulane Road | | | | 10f. ZIP CODE 21029 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) unknown | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | 16b. KIND OF BUSINESS/INDUSTRY Own home | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Carroll J. Reid | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rhea C. Unglaub | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. John B. Heflin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6125 Tulane Rd., Clarksville, MD 21029 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Balto-Wash Crematory | | | 20c. LOCATION — City or Town, State Laurel, MD | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> M00535 | | | | 22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A. Ellicott City, Maryland 21043 | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>MASSIVE MYOCARDIAL INFARCTION</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>CORONARY ARTERY DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | 29c. LICENSE NUMBER D25947 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wm. H. Heflin 5540 TOWNSHIP RD CLARKSVILLE MD 21029 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00359

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) NORMAN H. FIGGS, SR. | | | | 2. DATE OF DEATH MONTH 1 DAY 8 YEAR 94 | | 3. TIME OF DEATH 1:05p | |
| 4. SOCIAL SECURITY NUMBER 218-07-9941 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8/15/1920 | |
| 8. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto. City, Md. | | 9c. COUNTY OF DEATH Maryland | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Balto. Co. | | 10c. CITY, TOWN OR LOCATION Pasadena | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1414 Peace Drive | | | | 10f. ZIP CODE 21122 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.2 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th. Grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman | | 16b. KIND OF BUSINESS/INDUSTRY Sears Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles -- Figgs | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary --- Whittington | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Doris Schneider | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1414 Peace Drive, Pasadena, Md. 21122 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 1/14 | | 20c. DATE 1/14 | | 20d. LOCATION — City or Town, State Catonsville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Balto. Md. 21225 Ave. McCully Funeral Home, 237 E. Patapsco | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death 3 wks | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): | | | | 2 wks | |
| | | c. Leaky prosthetic aortic valve DUE TO (OR AS A CONSEQUENCE OF): | | | | ? | |
| | | d. _____ | | | | | |
| | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerosis (severe) | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | 29c. LICENSE NUMBER D41843 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CONFIDENTIAL

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00360

| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| FLORENCE REGINA FREEDENBURG FLORENCE R. FREEDENBURG | | | | | | MONTH DAY YEAR 01 07 94 | | 1:10 p.m. | | | |
| 4. SOCIAL SECURITY NUMBER 213-20-5090 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-5-1900 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Dulaney Towson Nursing Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | | 9c. COUNTY OF DEATH Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Towson | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 111 West Rd. | | | | 10f. ZIP CODE 21204 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Eugene Tilden Somerville | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Ellen Jamison | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Judith Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1092 Old Lathemtown Rd. Canton, Ga. 30115 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park | | DATE 1-10 | | 20c. LOCATION — City or Town, State Parkville, Md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Possible Aspiration Pneumonia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. POSSIBLE ASPIRATION PNEUMONIA b. DEMENTIA c. d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Sireesh Trifuranena | | | | | | 29c. LICENSE NUMBER D30661 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Sireesh Trifuranena 5670 Alemeda | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | | | | | | | | |

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

REG. NO.

94 00361

| | | | | | | | | | | | | | | | | | | | |
|--|--|--------------------------|--|---|--|---|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Frederick T. Gossman Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR January 8, 1994 | | | | 3. TIME OF DEATH 3:30 p. M | | | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 218-05-1169 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS NO | | IF UNDER 24 HRS. HOURS MIN. NO | | 7. DATE OF BIRTH (Month, Day, Year) Nov, 16, 1918 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 5210 Wright Avenue | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH ---- | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY ---- | | | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | | | | |
| 10e. STREET AND NUMBER 5210 Wright Avenue | | | | | | | | 10f. ZIP CODE 21205 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES World War II | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mold Polisher | | | | 16b. KIND OF BUSINESS/INDUSTRY Glass Company | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frederick C. Gossman | | | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine M. Schoenberger | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Frederick A. Gossman (Son) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5214 Wright Avenue, Baltimore, Md. 21205 | | | | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory 1/11 | | | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213 | | | | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Squamous Cell lung Cancer DUE TO (OR AS A CONSEQUENCE OF): b. Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. | | | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 038993 | | | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) House Officer 221 South Greene St. Balt. MD 21201 | | | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00362 | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) ERDIE M. GAMBLE | | | | 2. DATE OF DEATH MONTH 1 DAY 8 YEAR 94 | | 3. TIME OF DEATH 5:21 P.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 096 26 9120 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 59 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 10/6/34 | | 8. BIRTHPLACE (State or Foreign Country) S. CAROLINA | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE, MD | | 9c. COUNTY OF DEATH n/a | | | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10e. STREET AND NUMBER 901 DRUID PARK LAKE DRIVE apt. 2c | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY n/a | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) NATHANIEL HODGES | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) n/a | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) CYNTHIA ELEY | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1420 PENNSYLVANIA AVENUE, BALTIMORE, MARYLAND 21217 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.) VOSHELL MEMORIAL GARDE | | 20c. LOCATION — City or Town, State BALTIMORE CEMETERY | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James Cond | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Probable Sepsis & Shock DUE TO (OR AS A CONSEQUENCE OF): b. Metabolic Acidosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Michael Ieong M.D. | | | | 29c. LICENSE NUMBER 5679 | | 29d. DATE SIGNED (Month, Day, Year) 1/8/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL IEONG 22 S. GREENE ST, BALTIMORE, MD 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John Benison-Randall | | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | REG. NO. 94 00363 | |
|---|--|---|---|---|--|---|---|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) ADA C. GRADY | | | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN. 8 1994 | | 3. TIME OF DEATH 7:10 A M | |
| 4. SOCIAL SECURITY NUMBER 243-40-6731 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 65 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 11-13-19 | |
| 9a. FACILITY NAME (If not institution, give street and number) Meridian Hamilton N.C. | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5215 Wilton Heights Ave | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Aide | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Puyas Cobb | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maybell I. Davis | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gloria Jean Davis-Cox | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3221 Spaulding Ave Balto. MD 21215 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 1/12/94 | | 20c. LOCATION — City or Town, State Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature] | | | | 22. NAME AND ADDRESS OF FACILITY 1206 W. North Ave William C. Brown Community F.H. | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE b. CVA c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURED 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER Cherian Soares MD 29c. LICENSE NUMBER D16619 29d. DATE SIGNED (Month, Day, Year) 1/8/94 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. VERGARA-SOARES 100 N. BROADWAY ST. BALT. MD. 21231 31. DATE FILED (Month, Day, Year) JAN 11 1994 32. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | |

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00364

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Donald Frederick Germuth | | | | 2. DATE OF DEATH MONTH January DAY 5, YEAR 1994 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 219-18-8227 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 70 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 24, 1923 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Westminster | | 9c. COUNTY OF DEATH Carroll | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll County | | 10c. CITY, TOWN OR LOCATION Eldersburg | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6210 E. Hemlock Drive | | | | 10f. ZIP CODE 21784 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office Work | | 16b. KIND OF BUSINESS/INDUSTRY Clerical | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frederick George Germuth | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Elizabeth Brown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Alice M. Germuth | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6210 E. Hemlock Drive Eldersburg, MD 21784 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Serv. 1/6/94 | | 20c. LOCATION — City or Town, State Hampstead, MD | | 20d. DATE 1/6/94 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian D. Haight | | | | 22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (Box 195) Sykesville, MD 21784 (4100 795-1400) | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | Acute Cerebral Vascular Accident | | | | | Approximate Interval Between Onset and Death 1 day |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | Old Cerebral Vascular Accident | | | | | years |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Philip Knox | | | | 29c. LICENSE NUMBER D24321 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John D. Anderson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00365

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SARAH Elizabeth HALL | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 04 94 | | 3. TIME OF DEATH 2:21P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 579 20 4320 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 94 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-29-1899 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) GLADYS SPELLMAN NURSING CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY MD | | | 9c. COUNTY OF DEATH Prince George Co | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Prince George Co | | 10c. CITY, TOWN OR LOCATION Cheverly | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 2900 Mercy Lane | | | | 10f. ZIP CODE 20785 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES no | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) 3 | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Thompson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Thompson | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Albert Hall | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7810 Clark Rd, A-11 Holiday Mobile Estate Jessup, MD | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE | | 20c. LOCATION — City or Town, State | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Alzheimer's Disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death 10 yrs | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Don Yablonsky Attending Physician | | | | 29c. LICENSE NUMBER 021072 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Don Yablonsky, MD 10300 Greenbelt Rd, Seatons, MD 20706 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00366 | | | |
|---|--|---|---|--|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Margaret Anna Henne | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 09 94 | | 3. TIME OF DEATH 3:32 A. M | | | | | |
| 4. SOCIAL SECURITY NUMBER 215 18 6804 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 72 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 10/23/21 | | 8. BIRTHPLACE (State or Foreign Country) Md. | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Bel Air Convalescent Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Bel Air | | 9c. COUNTY OF DEATH Harford | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Fallston | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 2109 Folkstone Drive | | | | 10f. ZIP CODE 21047 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk | | 15b. KIND OF BUSINESS/INDUSTRY Pharmacy | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles McKay | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Margaret Hammerbacher | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Jo Ann Kendzejeski | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2109 Folkstone Dr. Fallston, Md. 21047 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore National Cemetery | | 20c. LOCATION — City or Town, State Balto., Md. | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler | | | | 22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 901 S. Conkling Street | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia, probably Viral</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Alzheimer's Disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Albert S.C. Sun, M.D. | | | | 29c. LICENSE NUMBER MD0018779 | | 29d. DATE SIGNED (Month, Day, Year) 1/9/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Albert S.C. Sun, M.D. 1800 Harford Rd. Fallston, MD 21047 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John Anderson | | | | | | | |

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00367

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LYDIA ANN HOPKINS | | | | 2. DATE OF DEATH MONTH 1 DAY 7 YEAR 94 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 216-42-4706 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 50 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3 19 43 | |
| 9a. FACILITY NAME (If not institution, give street and number) Mercy Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2220 N. Calvert Street | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeping | | 15b. KIND OF BUSINESS/INDUSTRY Unknown | | | |
| 17. FATHER'S NAME (First, Middle, Last) Robert Cross | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucille Jews | | | |
| 19a. INFORMANT'S NAME (Type/Print) Crystal Hopkins | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 540 Laurens Street Baltimore, Maryland 21217 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Cemetery 1/12/94 | | 20c. LOCATION — City or Town, State Baltimore, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY 1701 McCulloh St Chatman-Harris F/H Baltimore, Md 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Arterial Disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Diabetes mellitus II PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PVD S/P CVA Resp failure | | | | | | | Approximate Interval Between Onset and Death Yrs Yrs |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D 28998 | | 29d. DATE SIGNED (Month, Day, Year) 1-7-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9101 Cherry Lane #211 Lumbert MD 20708 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Division of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00368

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ALICETINE HOPKINS | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1994 | | 3. TIME OF DEATH 3:00 a.m. | |
| 4. SOCIAL SECURITY NUMBER 216-56-1178 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09/13/51 | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH MD. | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 423 N. MURA ST. | | | | 10f. ZIP CODE 21231 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) EUGENE HOPKINS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GERALDINE JENKINS | | | |
| 19a. INFORMANT'S NAME (Type/Print) GERALDINE HOPKINS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 N. CASTLE ST. BALTIMORE, MD 21205 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 1/13 | | 20c. LOCATION — City or Town, State LANDSDOWNE, MD. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE BETTS FUNERAL HOME | | | | 22. NAME AND ADDRESS OF FACILITY 1129 N. CAROLINE ST. BALTIMORE, MD. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Edema DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 7 week |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER David A. Garcia MD | | | | 29c. LICENSE NUMBER 10220 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID GARCIA Tower 110 JHH 600 Wolfe St. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00369

| | | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Milton E HOUSE | | | | 2. DATE OF DEATH MONTH DAY YEAR January 6, 1994 | | 3. TIME OF DEATH 9:38 A M | | | | |
| 4. SOCIAL SECURITY NUMBER 218-10-0916 | | 5. SEX 1 M 2 F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4-18-1916 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH Baltimore County | | | |
| 10a. STATE MD. | | 10b. COUNTY --- | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? YES 2 NO | | | |
| 10e. STREET AND NUMBER 524 S. Bouldin St. | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: white | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) --- College (1-4 or 5+) --- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Crane operator | | | 16b. KIND OF BUSINESS/INDUSTRY Crown Cork & Seal | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Milton B. House | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Shenbert | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Clara M. House | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 S. Bouldin St Balto, Md 21224 | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Cem. | | DATE 1/10 Balto., Md | | 20c. LOCATION — City or Town, State | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gay S. Smith | | | | 22. NAME AND ADDRESS OF FACILITY Hantley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma Involving the Liver DUE TO (OR AS A CONSEQUENCE OF): b. Carcinoma of Rectum DUE TO (OR AS A CONSEQUENCE OF): c. --- DUE TO (OR AS A CONSEQUENCE OF): d. --- | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malignant Fibrous Histiocytoma Left Thigh Muscle Group Excision | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Apparao N-V. Vanguri M.D. | | | | 29c. LICENSE NUMBER D19691 | | 29d. DATE SIGNED (Month, Day, Year) 1-5-1994 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) APPARAO N-V. VANGURI, M.D., 617-E STEMMERS RUN RD, BALTIMORE, MD. 21222 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John Davidson-Rodell | | | | | | |

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STATION REPORT
DATE
TIME
LOCATION
OBSERVER
WIND
TEMP
PRESS
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SEA
CLOUDS
VISIBILITY
REMARKS

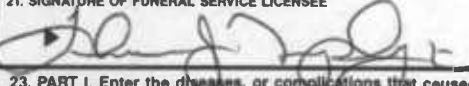
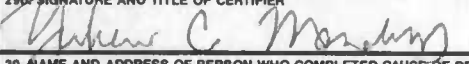

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00370

| | | | | | | | | | | | |
|--|--|---|--|---|-------------------------------------|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDWARD J. HINES, JR. | | | | 2. DATE OF DEATH MONTH January DAY 9 , 1994 YEAR | | 3. TIME OF DEATH 10:33 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-16-8636 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) April 20, 1922 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | 9c. COUNTY OF DEATH N/A | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore City | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 6021 Moyer Avenue | | | | 10f. ZIP CODE 21206 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales Service Manager | | | 16b. KIND OF BUSINESS/INDUSTRY Armco Steel | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward J. Hines, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie T. Krebs | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Doris Schnaitman Hines | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6021 Moyer Avenue, Baltimore, Maryland 21206 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith 1/13/94 | | | OATE 1/13/94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. CVA Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death 8 hrs 8 hrs | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. venalibic dependence | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | | 29c. LICENSE NUMBER 58092 | | 29d. DATE SIGNED (Month, Day, Year) 1/9/94 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KUKAR C MANAGE, 600 N. WOLFE ST, BALTO MD 21201 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 1/JAN 1 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

SECTION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00371

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mamie Viola Harter | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 8 94 | | 3. TIME OF DEATH 2:10 A. M | |
| 4. SOCIAL SECURITY NUMBER 215-50-9312 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 99 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 18, 1894 | |
| 8. FACILITY NAME (If not institution, give street and number) Bel Air Convalescent Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Bel Air | | 9c. COUNTY OF DEATH Harford | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Lutherville | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 123 Hedgewood Road | | | | 10f. ZIP CODE 21093 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES X | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary - Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) William F. Schools | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown Gertrude Tellis | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ruth H. Williams | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Hedgewood Road Lutherville, Md. 21093 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Jan. 11, 1994 | | DATE | | 20c. LOCATION — City or Town, State Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James J. Gladden | | | | 22. NAME AND ADDRESS OF FACILITY 1050 York Rd. 21204 Ruck Towson Funeral Home, Inc. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiopulmonary arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Dementia</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | |
| 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Linda Freilich M.D. | | | | 29c. LICENSE NUMBER 028339 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Linda Freilich M.D. 101 East Wheel Rd. Bel Air, Md. 21004 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00372

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JAMES JONES | | | | 2. DATE OF DEATH MONTH 1 DAY 3 YEAR 94 | | 3. TIME OF DEATH 10:09 P M | |
| 4. SOCIAL SECURITY NUMBER 256-30-9796 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/20/29 | |
| 8. BIRTHPLACE (State or Foreign Country) GEORGIA | | | | 9a. FACILITY NAME (If not institution, give street and number) Bon Secours Hospital, Inc | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH na | | | | 10a. STATE Md | | | |
| 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2018 LINDEN AVENUE | | | |
| 10f. ZIP CODE 21217 | | | | 10g. CITIZEN OF WHAT COUNTRY? US | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): STROKE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Sarkar | | 29c. LICENSE NUMBER 221649 | | 29d. DATE SIGNED (Month, Day, Year) 1-4-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SANBANDAY BASKARAN, 3455 Wilkens Ave, Baltimore MD 21229 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | 32. REGISTRAR'S SIGNATURE Sankar | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2P 00335



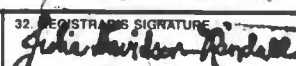
RECEIVED
COMMUNICATIONS

RECEIVED
COMMUNICATIONS

RECEIVED

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 84 00373 | |
|--|--|--|---|---|--|
| CERTIFICATE OF DEATH | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Robert Jones | | 2. DATE OF DEATH MONTH 1 DAY 7 YEAR 1994 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 213-28-9394 | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 60 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 5-23-1933 | 8. BIRTHPLACE (State or Foreign Country) Md | |
| 9a. FACILITY NAME (If not institution, give street and number) 6017 Deer Ridge Lane | | 9b. CITY, TOWN OR LOCATION OF DEATH Elkridge | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE Md | 10b. COUNTY HOWARD | 10c. CITY, TOWN OR LOCATION ELKRIDGE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6017 DEER RIDGE LANE | | 10f. ZIP CODE 21227 | | 10g. CITIZEN OF WHAT COUNTRY? U S A | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | |
| 14. RACE — American Indian, Black, White, etc. Specify Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) G.E.D. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LOGISTICS | | 16b. KIND OF BUSINESS/INDUSTRY FT. MEADE U.S. ARMY | |
| 17. FATHER'S NAME (First, Middle, Last) ODIE R. JONES | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARTHA GREEN | | | |
| 19a. INFORMANT'S NAME (Type/Print) MYRNA JONES | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 MILFORD AVE BALTO, MD 21207 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VETERAN 11394 | | 20c. LOCATION — City or Town, State OWINGS MILLS, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Balto, Md 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial Infarction Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. previous myocardial infarction, congestive heart failure | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | 29c. LICENSE NUMBER 0247281 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. GRAYSON JR OR NO 299 Breckinridge Road Balt MD 21215 | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | 32. REGISTRAR'S SIGNATURE  | | | |


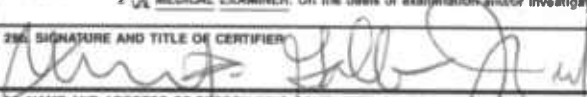
94-0104-510

DWG

FOR STATE REGISTRAR
 ITEMS: 23 PART I, II, 27, 28a-f, PER MEO FILM G-710 4/7/94 t.t.
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00374

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) FLORENCE KENNEDY | | | | 2. DATE OF DEATH MONTH 01 DAY 06 YEAR 94 | | 3. TIME OF DEATH 12:40 A.M. | |
| 4. SOCIAL SECURITY NUMBER 216 30 5147 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06 19 17 | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANCIS SCOTT KEY MEDICAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Essex | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1754 Eastern Blvd. | | | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Factory Worker | | 16b. KIND OF BUSINESS/INDUSTRY Western Electric | | | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Michael Murphy | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7916 Pulaski Highway Balto., Md. 21237 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 1-10-94 | | DATE | | 20c. LOCATION — City or Town, State Eastwood, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224 Eastern Ave. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE MYELOMA WITH COMPLICATIONS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INJURIES OF FACE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 1-6-94 | | 28b. TIME OF INJURY FOUND: 12:40 A.M. | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1754 EASTERN BLVD BALTIMORE, MD. | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/06/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLZ JR MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE MIDDLE EAST

94-0135-510

B.K.S

ITEM: 1. PER F.H. FILM G-707 1/11/94 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00375

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>CARL</u> <u>KNIGHT</u> | | | | 2. DATE OF DEATH MONTH <u>01</u> DAY <u>07</u> YEAR <u>94</u> | | 3. TIME OF DEATH <u>10:05</u> P M | |
| 4. SOCIAL SECURITY NUMBER <u>217- 96 - 0355</u> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>30</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>09- 01- 63</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>1441 LIMIT AVENUE APT. J</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE CITY, MD</u> | | 9c. COUNTY OF DEATH <u>n/a</u> | |
| 10a. STATE <u>MARYLAND</u> | | | | 10b. COUNTY <u>n/a</u> | | 10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u> | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <u>838 BENNINGHAUS ROAD</u> | | 10f. ZIP CODE <u>21212</u> | |
| 10g. CITIZEN OF WHAT COUNTRY? <u>JAMAICA</u> | | | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>XX</u> | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify <u>JAMAICAN</u> | | | | 14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 TH</u> College (1-4 or 5+) <u>UNEMPLOYED</u> | | | | 16. KIND OF BUSINESS/INDUSTRY <u>n/a</u> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <u>HENRIQUE KNIGHT</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>UNA LESLIE</u> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <u>UNA V. LESLIE</u> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>838 BENNINGHAUS ROAD, BALTIMORE, MARYLAND 21212</u> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____ | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <u>KING MEMORIAL PARK</u> DATE <u>01- 11</u> | | 20c. LOCATION — City or Town, State <u>MARYLAND</u> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Theresa Corp</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>WM. C. MARCH FH.- 1101 E. NORTH AVENUE</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Gunshot Wound of Head, Stab and Cutting Wounds and</u> DUE TO (OR AS A CONSEQUENCE OF): <u>b. Blunt Force Injuries of Head</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) <u>01/07/1994</u> | | 28b. TIME OF INJURY <u>9:45</u> P M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED <u>Subject stabbed, beaten</u> <u>SUBJECT CUT AND STABBED</u> | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>APARTMENT</u> | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>1441 LIMIT AVE. APT. J</u> | | | | 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dennis J. Clute MD</u> | | | | 29c. LICENSE NUMBER <u>O.C.M.E</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>01/08/1994</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>111 Penn Street, Baltimore, Maryland 21201</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 11 1994</u> | | | | 32. REGISTRAR'S SIGNATURE <u>Julia Benison-Russell</u> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows a traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00376

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) James Kenneth Knight Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR January 8, 1994 | | 3. TIME OF DEATH 5:A.M. M | |
| 4. SOCIAL SECURITY NUMBER 213-09-1437 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 4, 1915 | |
| 8. BIRTHPLACE (State or Foreign Country) Baltimore, Md. | | | | 9a. FACILITY NAME (If not institution, give street and number) 4259 B Chapel Road | | 9b. CITY, TOWN OR LOCATION OF DEATH Perry Hall | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Md. | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Perry Hall | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 4259 B Chapel Road | |
| 10f. ZIP CODE 21128 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist | | 16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel | |
| 17. FATHER'S NAME (First, Middle, Last) Harry Knight | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude | | | |
| 19a. INFORMANT'S NAME (Type/Print) June A. Knight | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4259 B Chapel Rd. Perry Hall, Md.-21128 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park 1-11 | | 20c. LOCATION — City or Town, State Baltimore, MD. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen M. Murphy</i> | |
| 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road Baltimore, Md.-21206 | | | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → 1. Parkinson's Disease DUE TO (OR AS A CONSEQUENCE OF): 2. AS HYP DUE TO (OR AS A CONSEQUENCE OF): 3. CVA large report DUE TO (OR AS A CONSEQUENCE OF): 4. Peritonitis bladder infection Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. W. W. ...</i> | | | | 29c. LICENSE NUMBER D07296 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00377

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Amrit Kaur | | 2. DATE OF DEATH MONTH DAY YEAR January 6, 1994 | | 3. TIME OF DEATH 9:55 A M | |
| 4. SOCIAL SECURITY NUMBER 295-74-8432 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) Jan. 1, 1912 | | 8. BIRTHPLACE (State or Foreign Country) India | | 9. COUNTY OF DEATH Baltimore | |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Md. | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 3 Durban Ct. | | 10f. ZIP CODE 21236 | |
| 10g. CITIZEN OF WHAT COUNTRY? India | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Indian | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | 17. FATHER'S NAME (First, Middle, Last) Mehtab Singh | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Payar Bhai | | 19a. INFORMANT'S NAME (Type/Print) Gurcharan Singh | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Durban Ct. Apt. L Baltimore, Md. 21236 | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Serv. Corp. 1/ 7/1994 | | 20c. LOCATION — City or Town, State Towson, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks, Jr. | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home Inc. 1050 York Rd. Towson, Md. 21204 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardio Renal Vascular Disease Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Uncontrolled Diabetes c. Fractured Left Hip | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | |
| 28a. DATE OF INJURY (Month, Day, Year) 1/2/94 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Charles F. O'Donnell MD | | 29c. LICENSE NUMBER D-09383 | |
| 29d. DATE SIGNED (Month, Day, Year) 1-6-94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Charles F. O'Donnell MD - 408 Harford Ave - Baltimore, MD 21204 | | 31. DATE FILED (Month, Day, Year) JAN 11 1994 | |
| 32. REGISTRAR'S SIGNATURE John A. ... | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00378

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) LORETTA H. KYNE | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN 8 1994 | | 3. TIME OF DEATH 2:00 AM | |
| 4. SOCIAL SECURITY NUMBER 212-32-8687 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 86 YRS. | 7. DATE OF BIRTH (Month, Day, Year) Nov. 4, 1907 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) SAINT JOSEPH HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON, MARYLAND | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Loch Raven Village | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1701 A Aberdeen Road | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs. | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesperson | | 16b. KIND OF BUSINESS/INDUSTRY Hecht's Department Store | | | |
| 17. FATHER'S NAME (First, Middle, Last) Anthony Bagrowski | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Stanislava Gulczynska | | | |
| 19a. INFORMANT'S NAME (Type/Print) Donald E. Kyne | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8503 Tallwood Road Lutherville, Maryland 21093 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem. 1/10/94 | | 20c. LOCATION — City or Town, State Overlea, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. CEREBRO VASCULAR ACCIDENT | | | | | Approximate interval Between Onset and Death 13 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. ATRIAL FIBILLATION | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D45060 | | 29d. DATE SIGNED (Month, Day, Year) 1/8/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANIS ANSARI 7620 YORK ROAD TOWSON, MARYLAND 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00379

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Bertha Matilda Lilley</i> | | | | 2. DATE OF DEATH MONTH <i>7</i> DAY <i>7</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>7:50 P M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>213-56-6087</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>76</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) <i>3-30-17</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Gilford, MD</i> | | | | 9. FACILITY NAME (If not institution, give street and number) <i>Golden Oaks Nursing Home</i> | | | |
| 10. RESIDENCE OF DECEDENT | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Laurel</i> | | 9c. COUNTY OF DEATH <i>Prince George</i> | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Howard</i> | | 10c. CITY, TOWN OR LOCATION <i>Laurel</i> | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>9527 North Laurel Road</i> | | | | 10f. ZIP CODE <i>20723</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i>0</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Home</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Orlando Edmonston</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bertha Krouse</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Herman L. Lilley</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9527 North Laurel Road Laurel, Maryland 20723</i> | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Baltimore Washington Crematory</i> | | 20c. LOCATION — City or Town, State <i>Laurel, Maryland</i> | | 20d. DATE <i>7-7-94</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kalish & Daugherty</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, MD 20707</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i> | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): <i>Cerebrovascular accident</i> | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): <i>atrial fibrillation</i> | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER <i>1042767</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>7/8/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Chris Manick 8317 Cham Lane Laurel, MD</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 11 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate is to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00380

| | | | | |
|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) TONI V. LITTLE | | 2. DATE OF DEATH MONTH 01 DAY 05 YEAR 94 | | 3. TIME OF DEATH 12:45 A |
| 4. SOCIAL SECURITY NUMBER 245-90-3216 | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 41 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 5-16-1952 | 8. BIRTHPLACE (State or Foreign Country) N.C. |
| 9a. FACILITY NAME (If not institution, give street and number) VAMC | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER # 3 Woodthorne Court # 12 | | 10f. ZIP CODE 21117 |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES Viet Nam |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: Black | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY Army | | 17. FATHER'S NAME (First, Middle, Last) Warren Utah |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maude Woolard | | 19a. INFORMANT'S NAME (Type/Print) Cynthia L. Brower | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Woodthorne Court #12, Dwings Mill, Md 21117 |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hassell Cemetery | | 20c. LOCATION — City or Town, State Williamsburg, N.C. 27892 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eugene M. [Signature]</i> | | 22. NAME AND ADDRESS OF FACILITY Estep Bros. Funeral Home P.A. 1300 Ertaw Place BA Ho. MD 21217 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. SARCOIDOSIS b. OGILVIES SYNDROME |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kathleen [Signature]</i> MD | | 29c. LICENSE NUMBER |
| 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10 S. Greene St. Baltb., MD 21201 | | 31. DATE FILED (Month, Day, Year) 1/JAN/1 1994 |
| 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | 33. DATE OF DEATH (Month, Day, Year) 1/5/94 | | 34. TIME OF DEATH 12:45 A |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00381 | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Elizabeth R. Lowe | | | | 2. DATE OF DEATH MONTH DAY YEAR 01-09-94 | | | | 3. TIME OF DEATH 20:45pm | | | | | |
| 4. SOCIAL SECURITY NUMBER 549-10-2433 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06.03.09 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) WELLSPRING NURSING CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie, | | | | 9c. COUNTY OF DEATH ANNE ARUNDEL | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Howard County | | 10c. CITY, TOWN OR LOCATION Ellicott City | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 8540 W. Main Street | | | | 10f. ZIP CODE 21043 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress | | | | 16b. KIND OF BUSINESS/INDUSTRY Woolen Mill | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) George E. Bopst | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cecelia Sparmer | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Pauline Teal | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 785 Gordon Circle, Apt. 587 Glen Burnie, MD 21060 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Springfield Cemetery Jan. 12, 1994 Sykesville, Maryland | | | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian L. Haight | | | | 22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): Dilated cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. * Severe anemia * Arterio-venous malformation | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D41927 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3708 Mountain Rd Pasadena, MD 21122 Jorge Recz-Alamo | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00382

| | | | | | | | | | | | |
|--|--|---|--|--|--|--|---------------------|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) Ida G. Milbourne | | | | 2. DATE OF DEATH MONTH 1 DAY 7 YEAR 1994 | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER 215-10-7580 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-29-15 | | 8. BIRTHPLACE (State or Foreign Country) ALA. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 3218 Dorithain Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH | | | | |
| RESIDENCE OF DECEASED | | | | 10a. STATE MD | | 10b. COUNTY BALTO | | 10c. CITY, TOWN OR LOCATION BALTO | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3218 DORITHIAN RD | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER | | 16b. KIND OF BUSINESS/INDUSTRY BALTO CITY SCHOOL | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN GRAY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY PENDLETON | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) WILLIAM JORDAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8958 S. HAMILTON AVE CHICAGO, ILL 60620 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) BALTIMORE NATIONAL CEM 11294 | | DATE BALTO, MD | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ida March | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOPULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): b. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. CORONARY ARTERIOSCLEROSIS DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death 1 week 2 years 2 years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Jules N. Fonda | | | | 29c. LICENSE NUMBER 034041 | | 29d. DATE SIGNED (Month, Day, Year) January 10, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jules N. Fonda 5601 Locust Raven Blvd. Baltimore, Md. 21239 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia L. Fonda | | | | | | | |

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00383

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ERNEST MARTIN | | | | 2. DATE OF DEATH MONTH 01 DAY 01 YEAR 94 | | 3. TIME OF DEATH 5 56P M | |
| 4. SOCIAL SECURITY NUMBER 230 88 7065 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) | |
| 9a. FACILITY NAME (If not institution, give street and number) Prince George Co Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cheverly | | 9c. COUNTY OF DEATH Prince Geo Co | |
| 10a. STATE Maryland | | | | 10b. COUNTY Prince Geo Co | | 10c. CITY, TOWN OR LOCATION New Carrollton | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 5420 85th Avenue T-1 | | | |
| 10f. ZIP CODE 20784 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk | | 16b. KIND OF BUSINESS/INDUSTRY Safeway Food Stores | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state removal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i> | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → pneumonia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. acquired immune deficiency syndrome c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumo thorax | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>George C. Hajjar, Jr. MD</i> | | | | 29c. LICENSE NUMBER 039550 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George C. Hajjar, Jr. MD 4850 Forbes Blvd Lanham, MD 20706 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John T. Anderson</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00384

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CELESTINE | | AKA Mary Celestine McCardell MCCARDELL | | 2. DATE OF DEATH MONTH JANUARY DAY 8th YEAR 1994 | | 3. TIME OF DEATH 1:30 AM | | | |
| 4. SOCIAL SECURITY NUMBER 212-32-3335 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 25, 1909 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION TOWSON | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2 C Smeton Place Dulaney Towers | | | | 10f. ZIP CODE 21204 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 15b. KIND OF BUSINESS/INDUSTRY Homemaker | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Patrick Hynes | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ann Hynes | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) J. Neil McCardell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 C Smeton Place Towson, MD 21204 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cem. | | DATE JAN | | 20c. LOCATION — City or Town, State Baltimore City, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, MD 21093 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE EXACERBATION DUE TO (OR AS A CONSEQUENCE OF): WITH RESPIRATORY FAILURE b. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 1 DAY 3 WEEKS | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER DR OWIREDA-ADDO MD | | 29c. LICENSE NUMBER #032 | | 29d. DATE SIGNED (Month, Day, Year) JANUARY 8th 1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GOOD SAMARITAN HOSPITAL 1001 RAVEN BOULEVARD BALTIMORE | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | 32. REGISTRAR'S SIGNATURE John Sanders-Randall | | | | | | |

10-7-68



10-7-68



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00385

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) DUANE A MORELAND | | | | 2. DATE OF DEATH MONTH 01 DAY 09 YEAR 94 | | 3. TIME OF DEATH 10:35 AM | |
| 4. SOCIAL SECURITY NUMBER 214-46-0482 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 46 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06 14 47 | |
| 8a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION | | | | 8b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | | 8c. COUNTY OF DEATH A.A. COUNTY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION GLEN BURNIE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 150 HAMMARLEE ROAD APT:A | | | | 10f. ZIP CODE 21060 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONSTRUCTION WORKER | | 16b. KIND OF BUSINESS/INDUSTRY ROAD CONSTRUCTION | |
| 17. FATHER'S NAME (First, Middle, Last) DUANE O. MORELAND | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HAZEL I. MCKIM | | | |
| 19a. INFORMANT'S NAME (Type/Print) DUANE O. MORELAND | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX #402 MILLERSVILLE, MARYLAND 21108 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY, INC. 1/10 | | 20c. LOCATION - City or Town, State CATONSVILLE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i> | | | | 22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Hypotension</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>SEPSIS</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>DIABETES</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>CIRRHOSIS OF LIVER</u> | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>SEVERE MALNUTRITION</u> <u>RENAL INSUFFICIENCY</u> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER D38958 | | 29d. DATE SIGNED (Month, Day, Year) 1/9/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DALJEET S. SIDHU, M.D./1413 ANNAPOLIS ROAD, SUITE 106/ODENTON, MARYLAND 21113 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

BALTIMORE, MARYLAND 21215-0020

68760

TO THE HOSPITAL OR FUNERAL HOME: This certificate must be filed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: This certificate must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CH FORD

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 94 00386 | | | |
|--|--|--|---|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) THOMAS RAPHAEL McKENNA | | | | 2. DATE OF DEATH MONTH DAY YEAR January 8, 1994 | | | | 3. TIME OF DEATH M | | | |
| 4. SOCIAL SECURITY NUMBER 577-40-4023 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 78 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 10/3/1915 | 8. BIRTHPLACE (State or Foreign Country) Canada | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Joseph Manor | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore City | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 911 W. Lake Ave. | | | | 10f. ZIP CODE 21210 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Catholic Priest | | 16b. KIND OF BUSINESS/INDUSTRY Church | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Swithin William | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lily Beatrice McBride | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) St. Joseph Society of the Sacred Heart | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 N. Calvert St. Baltimore, MD 21202 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Peter Seven Mile Bay Cem/ 1/14/94 | | 20c. LOCATION — City or Town, State Kinkora, Prince Edward Island | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul L. Hartsock, Jr. <i>Paul L. Hartsock, Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Competitive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>George LaRocca</i> George LaRocca, M.D. | | 29c. LICENSE NUMBER 016006 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George LaRocca, M.D. O'Dea Medical Building Suite 502 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John S. ...</i> | | | | | | | |

28800 42

RECEIVED

3

SECRET

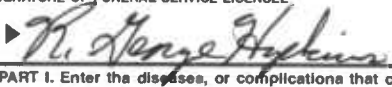
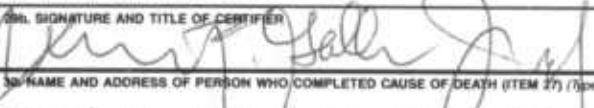
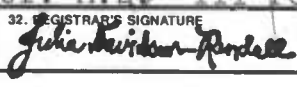
94-0124-510

blh

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00387

| | | | | |
|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Richard L. Moore | | 2. DATE OF DEATH MONTH 01 DAY 07 YEAR 1994 | | 3. TIME OF DEATH 0907 M |
| 4. SOCIAL SECURITY NUMBER 214-30-2845 | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 59 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 10-29-34 | 8. BIRTHPLACE (State or Foreign Country) MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE MD | 10b. COUNTY N/A | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 10e. STREET AND NUMBER 1216 SOUTH HANOVER STREET | | 10f. ZIP CODE 21230 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES KOREAN | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HELPER | | 17. KIND OF BUSINESS/INDUSTRY CROSS STREET MARKET | | |
| 17. FATHER'S NAME (First, Middle, Last) JAMES T. MOORE, SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET A. SMITH | | |
| 19a. INFORMANT'S NAME (Type/Print) CHARLES E. MOORE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 656 CHARANTE COURT APT. 202, GLEN BURNIE, MD 21061 | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK 1/11 | | 20c. LOCATION — City or Town, State GLEN BURNIE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Inquiry |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER  | | |
| 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01 07 1994 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print) Mario F. Golle Jr. M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | 32. REGISTRAR'S SIGNATURE  | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



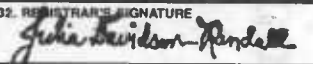
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00388 | | | |
|--|--|---|--|--|--|---|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | |
| Francis E. O'Rourke | | | | Jan. 6, 1994 | | | | 11:15 A. M. | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 178-18-9319 | | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 86 YRS. | | Sept. 18, 1907 | | Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| 5311 Bush Street | | | | White Marsh | | | | Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | | | |
| Maryland | | Baltimore | | White Marsh | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 5311 Bush Street | | | | 21162 | | | | U.S.A. | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | | | |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | Specify: White | | | | | |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | IF YES, GIVE WAR OR DATES | | Specify: | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12) N/A | | | | College (1-4 or 5+) N/A | | | | Asst. Vice President Bank | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| Bernard O'Rourke | | | | Caroline Jones | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| Francis E. O'Rourke, Jr. (son) | | | | 5311 Bush St., White Marsh, MD 21162 | | | | | | | |
| 20a. METHOD OF DISPOSITION | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | 20c. LOCATION — City or Town, State | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | | | | Holy Cross Cemetery | | | | Yeadon, PA | | | |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
|  | | | | Schimunek Funeral Homes, Inc. | | | | | | | |
| | | | | 9705 Belair Rd., Baltimore, MD 21236 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cerebrovascular accident</u> | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| b. _____ | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| c. _____ | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| d. _____ | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? | | | | | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | | | | | | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | | | | | |
|  | | | | | | | | | | | |
| 29c. LICENSE NUMBER | | | | | | | | | | | |
| DO 6240 | | | | | | | | | | | |
| 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | |
| JAN 6 1994 | | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| Dr. Emory Lindner, 902 Averill Road, Joppa, MD 21085 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |
| JAN 11 1994 | | | |  | | | | | | | |

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94-0069-510

DWG

ITEMS: 23 PART I, II, 27, 28a-f, PER MEO FILM G-709 3/7/94 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00389

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANTOINE OLIVER, LEROY SR. | | | | 2. DATE OF DEATH MONTH 01 DAY 03 YEAR 94 | | 3. TIME OF DEATH 6:59 P M | |
| 4. SOCIAL SECURITY NUMBER 214-78-8561 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 32 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-7-61 | |
| 9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE md. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1215 N. BRADFORD ST. | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) George L. Oliver | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CARLIE HARRIS | | | |
| 19a. INFORMANT'S NAME (Type/Print) CARLIE HARRIS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 N. ROSE ST. BALTIMORE, MD 21205 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY | | 20c. LOCATION — City or Town, State BALTIMORE, MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Betts Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY 1129 N. CAROLINE ST. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE COCAINE AND NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 1-3-94 | | 28b. TIME OF INJURY 6:37 P M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1215 BRADFORD STREET BALTIMORE, MARYLAND | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Renn J. Chuteau | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/04/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE Julie Benson-Russell | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00390 | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Leroy Powell | | | | 2. DATE OF DEATH MONTH DAY YEAR January 6, 1994 | | | | 3. TIME OF DEATH 8:18 A M | | | |
| 4. SOCIAL SECURITY NUMBER 246-14-4159 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-8-1907 | | 8. BIRTHPLACE (State or Foreign Country) N.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE Md | | | | 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION Baltimore City | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER Seton Hill Manor N/H 501 W. Franklin St | | | | 10f. ZIP CODE 21201 | | | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Robert Powell | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 W. Belvedere Avenue Baltimore, Md 21215 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt Zion Cemetery 11094 | | | | 20c. LOCATION — City or Town, State Lansdown, Md | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale March | | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Baltimore, Md 21215 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIORESPIRATORY Arrest b. PULMONARY FAILURE c. CHF d. SEQUENTIALLY ILL CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Warren Smith | | | | 29c. LICENSE NUMBER D24148 | | 29d. DATE SIGNED (Month, Day, Year) 1-10-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WARREN SMITH MD 3502 W ROBERT DR #6 BAL MD 21215 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John L. ... | | | | | | | |

FOR
STATE
1 - REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Mildred Phillips | | | | 2. DATE OF DEATH MONTH: 1 DAY: 5 YEAR: 94 | | 3. TIME OF DEATH 1718 M | |
| 4. SOCIAL SECURITY NUMBER 213-70-0893 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 55 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/1/38 | |
| 8. BIRTHPLACE (State or Foreign Country) S.C. | | | | 9a. FACILITY NAME (If not institution, give street and number) 712 E. Preston St | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO. | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Maryland | | | |
| 10b. COUNTY Baltimore City | | | | 10c. CITY, TOWN OR LOCATION Baltimore City | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 712 E. Preston Street | | | |
| 10f. ZIP CODE 21202 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unemployed | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joe Boyd | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Woodard | | | |
| 19a. INFORMANT'S NAME (Type/Print) Judy Johnson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 E. Preston St. BALTO. Md 21205 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTO. Cem. | | 20c. LOCATION — City or Town, State BALTO. Md | | 20d. DATE 1/11/94 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Betts Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY 1129 N. Caroline St | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Asthma DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. Diabetic ketoacidosis | | | | | | | |
| Approximate interval Between Onset and Death 1 wk. 2-3 days 15 yrs 2-3 days | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Christopher Mark Watke MD | | | | 29c. LICENSE NUMBER pending | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christopher Mark Watke MD 301 St. Paul Place Baltimore, Md 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE Joe Andrew Roberts | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10300 2



94-0092-510

DWG

UNK 94-003

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-708 2/2/94 t.t.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00392

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM BUBBY PRAYLOW | | | | 2. DATE OF DEATH MONTH 01 DAY 05 YEAR 94 | | 3. TIME OF DEATH 01:30 P M | |
| 4. SOCIAL SECURITY NUMBER 216-74-6743 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 35 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-08-58 | |
| 9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH n/a | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 2625 E. MADISON STREET | | | | 10f. ZIP CODE 21205 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED | | 15b. KIND OF BUSINESS/INDUSTRY n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last) WILLIAM KELLY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH PRAYLOW | | | |
| 19a. INFORMANT'S NAME (Type/Print) ALBERTA LEGGETTE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2625 E. MADISON STREET, BALTIMORE, MARYLAND 21205 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) BALTIMORE CEMETERY | | 20c. DATE 01-11 | | 20d. LOCATION — City or Town, State BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>NARCOTIC INTOXICATION</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input checked="" type="checkbox"/> Could not be determined 6 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 1-5-94 | | 28b. TIME OF INJURY UNKNOWN M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND ON STREET | | | |
| | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ASHLAND AVE. & GLOVER ST. BALTIMORE, MARYLAND | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/06/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARGARET A. KORSE 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00394

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Virgie Mary Raygor | | | | 2. DATE OF DEATH MONTH DAY YEAR 1/8/1994 | | 3. TIME OF DEATH M M | | | | | |
| 4. SOCIAL SECURITY NUMBER 220-24-2324 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3/31/1907 | | 8. BIRTHPLACE (State or Foreign Country) Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 3647 Keystone Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH City | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Md | | 10b. COUNTY City | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3647 Keystone Avenue | | | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4 or 5+) Homemaker | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 15b. KIND OF BUSINESS/INDUSTRY ----- | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Daniel Ywell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Nancey Armercrout | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gertrude Sherwood | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3647 Keystone Avenue Balto, MD 21211 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 1/11 | | DATE 1/11 | | 20c. LOCATION — City or Town, State Glen Burnie, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael Carpenter</i> | | | | 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Rd. Balto, MD 21211 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest a. DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic Cardiovascular Disease b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma of Breast Decubitus Ulcer Rheumatoid Arthritis | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>William D. McConnell MD</i> | | | | 29c. LICENSE NUMBER D42129 | | | | 29d. DATE SIGNED (Month, Day, Year) 1-10-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William D. McConnell 500 W. University Baltimore 21210 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Burdick-Randall</i> | | | | | | | |

Item4
1-11-94 FilmG707 W.H. per F/H

94 00395

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|---|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Adelaide J. Russell | | 2. DATE OF DEATH MONTH DAY YEAR January 10, 1994 | | 3. TIME OF DEATH 4:44 a |
| 4. SOCIAL SECURITY NUMBER 223-32-2911 | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 83 YRS. | 7. DATE OF BIRTH (Month, Day, Year) August 10, 1910 | 8. BIRTHPLACE (State or Foreign Country) North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number) BROADMEAD | | 9b. CITY, TOWN OR LOCATION OF DEATH Cockeysville | | 9c. COUNTY OF DEATH Baltimore |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Cockeysville |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 13801 York Road | | |
| 10f. ZIP CODE 21030 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY Homemaker | | |
| 17. FATHER'S NAME (First, Middle, Last) John Moose Julian | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Adelaide Bedford | | |
| 19a. INFORMANT'S NAME (Type/Print) John J. Russell | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15601 Chilcoat Rd., Sparks, MD 21152 | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. | | 20c. LOCATION — City or Town, State Catonsville, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, MD 21093 | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Urosepsis Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Mixed Dementia a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 1/10/94 | | 28b. TIME OF INJURY M |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Walter Hepner, III, M.D. | | |
| 29c. LICENSE NUMBER D23450 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Walter Hepner, III, M.D. 3313 Paper Mill Road, Phoenix, MD 21131 | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | 32. REGISTRAR'S SIGNATURE [Signature] | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 20 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00396 | | | |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | |
| AGNES SCHENKEL | | | | JANUARY 8, 1994 | | | | 1:46 a.m. | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 213-10-7537 | | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 85 YRS. | | MAY 8, 1908 | | Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| MARYLAND GENERAL HOSPITAL | | | | BALTIMORE CITY | | | | BALTIMORE CITY | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | | | |
| 10a. STATE | | | | 10b. COUNTY | | Baltimore | | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10a. STREET AND NUMBER | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | |
| The Wesley Home 2211 W. Rogers Avenue | | | | 21209 | | USA | | | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | | | |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | Specify: white | | | | | |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | IF YES, GIVE WAR OR DATES | | Specify: | | | | | | | |
| 15. DECEDENT'S EDUCATION | | | | 16a. DECEDENT'S USUAL OCCUPATION | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| (Specify only highest grade completed) | | | | (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | |
| Elementary/Secondary (0-12) | | | | College (1-4 or 5+) | | Homemaker | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| Willard Schenkel | | | | Sarah Catherine Spates | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| The Wesley Home | | | | 2211 W. Rogers Ave. Balto., MD 21209 | | | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | | Mt. Olivet Cemetery 1/12 | | Baltimore, MD | | | | | | | |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| <i>Tracy Henss Carpenter</i> | | | | Burgee-Henss Funeral Home 3631 Falls Rd Baltimore, MD 21211 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | | |
| a. CARCINOMA OF THE COLON | | | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| c. CARCINOMATOSIS — CARCINOMA METASTASIS TO THE LIVER | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| e. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| f. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| g. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| h. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| i. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| j. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| k. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| l. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| m. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| n. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| o. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| p. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| q. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| r. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| s. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| t. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| u. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| v. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| w. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| x. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| y. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| z. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| ARTERIAL OCCLUSION | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? | | | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | | | M | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| | | | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICENSE NUMBER | |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | KHOSROW TABASSI, MD HO. | | | | | | 29d. DATE SIGNED (Month, Day, Year) | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 1-8-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| KHOSROW TABASSI, MD. c/o MARYLAND GENERAL HOSPITAL | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |
| JAN 11 1994 | | | | <i>Julia Swickard-Podell</i> | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | | 94 00397 | | | |
|--|--|--|--|--|--------------------------------|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Ruby V. Satterfield | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 10, 1994 | | 3. TIME OF DEATH 10:50 a. m. | | | | | |
| 4. SOCIAL SECURITY NUMBER 317-05-9869 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 84 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Nov. 30, 1909 | | 8. BIRTHPLACE (State or Foreign Country) Indiana | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Meridian Long Green | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH --- | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY --- | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 3515 Dudley Avenue | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Koenig | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Rachel Newman | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Diane E. Schwoerer (Dghtr) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7811 Poplar Grove Road, Severna Park, Md. 21144 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 1/12 | | DATE Baltimore, Maryland | | 20c. LOCATION — City or Town, State | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert J. Adcock | | | | 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Baltimore, Md. 21213 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Ovarian Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Fred Sirkis | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/11/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Fred Sirkis, 7151 Hollabird Avenue, Baltimore, Md. 21222 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. SIGNATURE OF REGISTRAR Julia Davidson-Randall | | | | | | | |

RECEIVED
JAN 1 1971

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00398

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WARREN SOMERVILLE | | | | 2. DATE OF DEATH MONTH 01 DAY 09 YEAR '94 | | | | 3. TIME OF DEATH 2:15 P. M | |
| 4. SOCIAL SECURITY NUMBER 215-18-5650 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 01 1921 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON | | | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Sparks | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 13927 York Road | | | | 10f. ZIP CODE 21152 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 3 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Commercial Artist | | | 16b. KIND OF BUSINESS/INDUSTRY Artist | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles William Somerville | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Mae Garretson | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Anne Tyler Somerville | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13927 York Road, Sparks, MD 21152 | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Jan. 10, 1994 Catonsville, MD | | | 20c. LOCATION — City or Town, State | | 20d. LOCATION — City or Town, State | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin D. Lawson | | | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld, Inc. 10 W. Padonia Rd., Timonium, MD 21093 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hepatic failure Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Metastatic Colon ca PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes/ nephrotic syndr. | | | | | | | | | Approximate Interval Between Onset and Death 3 wks 2 wks |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ruth Kantor, M.D. | | | | 29c. LICENSE NUMBER 1028594 | | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Ruth Kantor, M.D. 6565 N. Charles St., Towson, MD 21204 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020. The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, item 23 allows any injury, or other traumatic event, the medical examiner must be notified at once.

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143

94-0038-510
B.K.S

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00399

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VERNON M. STOKES | | | | 2. DATE OF DEATH MONTH 01 DAY 02 YEAR 94 | | 3. TIME OF DEATH 10:10 PM | |
| 4. SOCIAL SECURITY NUMBER 180-14-8266 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 08-07-17 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) 4800 YELLOWWOOD ROAD APT. #207 | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH n/a | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY n/a | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 4800 YELLOWWOOD ROAD APT. 207 | | | |
| 10f. ZIP CODE 21209 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) n/a | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PAINTER | | 16b. KIND OF BUSINESS/INDUSTRY ALBERT ESTEEN MEDICAL CENTER | |
| 17. FATHER'S NAME (First, Middle, Last) DANIEL A. STOKES | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) BLANCHE FAX | | | |
| 19a. INFORMANT'S NAME (Type/Print) IVY GOOD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 YELLOWWOOD ROAD, BALTIMORE, MARYLAND 21209 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHILL MEMORIAL GARDEN 01-08 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kesiah Chapman</i> | | | | 22. NAME AND ADDRESS OF FACILITY W. M. C. MARCH FH.- 1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>inspection</i> | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i> | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) 01/03/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Sanderford</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the death has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked "Other", the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | |
|--|--|---|--|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>William H. Swisher</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>7</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>2:05 A</i> M | | |
| 4. SOCIAL SECURITY NUMBER <i>212-14-0580</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>83</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>11-24-1910</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Church Home Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | | 9c. COUNTY OF DEATH <i>Baltimore</i> | |
| 10a. STATE <i>Md</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>431 N. Montford Ave.</i> | | | | 10f. ZIP CODE <i>21224</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Electrician</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Construction</i> | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>James S. Swisher</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Alice Smith</i> | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Juanita M. Swisher</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>431 N. Montford Ave. Balto., Md 21224</i> | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oaklawn Cem.</i> | | 20c. LOCATION — City or Town, State <i>1110 Balto., Md</i> | | 20d. DATE | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gay S. Smith</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Hantley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234</i> | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>s. Prob pulm embolus</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. malnutrition</i> c. d. Approximate Interval Between Onset and Death <i>hrs</i> <i>yrs</i> | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CVA x2</i> | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD Family</i> | | | | 29c. LICENSE NUMBER <i>D18587</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/7/94</i> | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Paul Gormley 100 N Broadway Balto MD 21231</i> | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 11 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | |

94-0141-510

blh

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00401

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Denton L. Seebo, Jr. | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 08 1994 | | 3. TIME OF DEATH M 0927 | |
| 4. SOCIAL SECURITY NUMBER 218-90-4889 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 30 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-17-1963 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | |
| 10. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 11. COUNTY OF DEATH --- | | | |
| 12a. STATE Md | | 12b. COUNTY Baltimore | | 12c. CITY, TOWN OR LOCATION Baltimore | | 12d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 13. STREET AND NUMBER 2911 Alvarado Sq. | | | | 14. ZIP CODE 21234 | | 15. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 16. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 19. RACE — American Indian, Black, White, etc. Specify: white | |
| 20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custom Car Cleaner | | 22. KIND OF BUSINESS/INDUSTRY Shanahan's Car Wash | | | |
| 23. FATHER'S NAME (First, Middle, Last) Denton L. Seebo | | | | 24. MOTHER'S NAME (First, Middle, Maiden Surname) Marlene E. Schmidt | | | |
| 25. INFORMANT'S NAME (Type/Print) Mr. Denton L. Seebo, Jr. | | | | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2908 Oakrest Ave. Balto., Md 21234 | | | |
| 27a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 27b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Mem Cem 1/13 | | 27c. LOCATION — City or Town, State Balto., Md | | | |
| 28. SIGNATURE OF FUNERAL SERVICE LICENSEE Spady S. Smith | | | | 29. NAME AND ADDRESS OF FACILITY Hantley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pulmonary Thrombo-embolism DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of diabetes mellitus Cardiac hypertrophy | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Clute | | | | 29c. LICENSE NUMBER O C M E | | 29d. DATE SIGNED (Month, Day, Year) 01 08 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | REGISTRAR'S SIGNATURE Julia Gordon-Rodell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | | | REG. NO. 94 00402 | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) BESSIE E. SPRINGS | | | | 2. DATE OF DEATH MONTH 01 DAY 04 YEAR 94 | | | | 3. TIME OF DEATH 3:40 A.M. | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-32-4589 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 96 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 11/20/1897 | | 8. BIRTHPLACE (State or Foreign Country) AQUASCO, MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | | | | | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10e. STREET AND NUMBER 3800 BELVEDERE AVE. | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: AFO. AMERICAN | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) LEWIS GROSS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GEORGEANNA GROSS | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) ELISE DENT | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19204 AQUASCO RD. BRANDYWINE, MARYLAND 20613 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHRIST U.M. CHURCH CEM. 1/8/94 BADEN, MARYLAND | | 20c. LOCATION — City or Town, State | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL SER, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Sepsis</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 2 wks 2 wks 4 wks | | | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D-44002 | | 29d. DATE SIGNED (Month, Day, Year) 01/04/94 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JITO TANGUILIG LIBERTY Med. Center Balto MD 21215 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

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REVISED FROM

1950

Handwritten signature or initials

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00403

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|-----------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Frank Joseph Swift | | | | 2. DATE OF DEATH MONTH DAY YEAR 1-4-1994 | | 3. TIME OF DEATH 6:13 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-01-5155 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 85 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-12-1908 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital Association | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | | | 9c. COUNTY OF DEATH Anne Arundel | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Baltimore (Brooklyn Park) 3--Thirteenth-Avenue | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 3 Thirteenth Avenue Baltimore, (Brooklyn Park) | | | | 10f. ZIP CODE 21225 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Supervisor of Receiving | | | 16b. KIND OF BUSINESS/INDUSTRY Montgomery Wards Co. | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Swierczewski | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Adela Michalski Swierczewski | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Ida S. Swift | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Thirteenth Ave., Baltimore, Maryland 21225 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery 1/7/94 | | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker | | | | 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Ca. Pneumonia & mets to liver</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate interval Between Onset and Death 6 mo. | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Lung Disease</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lee MD</i> | | | 29c. LICENSE NUMBER D17743 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. L. Seenivasan, M.D. 606 Hammonds Lane, Baltimore, Maryland 21225 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | | 32. REGISTRAR'S SIGNATURE <i>John S. ...</i> | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2285-85



TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00405

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|----------------------------------|---|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDMUND DAVID SCHREIBER, SR. | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 07 94 | | 3. TIME OF DEATH M | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 705-10-2432 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 06/10/1900 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) AUGSBURG LUTHERAN HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH PIKESVILLE | | | 9c. COUNTY OF DEATH BALTIMORE | | | | | | |
| 10a. STATE MD | | | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION PIKESVILLE | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 6811 CAMP FIELD ROAD | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (13-16) 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RAILROAD INSPECTOR | | 16b. KIND OF BUSINESS/INDUSTRY B & O RAILROAD | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN D. SCHREIBER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET HARDUSEN | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARY A. BOPP | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1417 WOODCLIFF RD., BALTIMORE, MD 21228 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK | | DATE 01/10 | | 20c. LOCATION — City or Town, State GLEN BURNIE, MD | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. H. Haskins</i> | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Adenocarcinoma of prostate</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>VENOUS STASIS with venous ulcers</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Tasneem Lakhani MD</i> | | 29c. LICENSE NUMBER <i>D2885</i> | | 29d. DATE SIGNED (Month, Day, Year) JANUARY 10, 1994 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. TASNEEM LAKHANI 7220 PARK HEIGHTS AVE., BALTIMORE, MARYLAND 21215 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Fish Davidson-Rodriguez</i> | | | | | | | | | |

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RECEIVED
FEBRUARY 1961

1001 / 1961

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00406


| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Charles Sessa | | | | 2. DATE OF DEATH MONTH DAY YEAR 1-1-94 | | 3. TIME OF DEATH 3:03 A. M | | | |
| 4. SOCIAL SECURITY NUMBER 065-16-3212 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-28-1912 | | 8. BIRTHPLACE (State or Foreign Country) New York | |
| 9a. FACILITY NAME (If not institution, give street and number) Edw. W. McCready Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Crisfield | | | 9c. COUNTY OF DEATH Somerset | | |
| 10a. STATE Maryland | | 10b. COUNTY Somerset Co | | 10c. CITY, TOWN OR LOCATION Crisfield | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 306 Myrtle St | | | | 10f. ZIP CODE 21817 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES No | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY Construction | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Sessa | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MaBelle Sessa | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Myrtle St, Crisfield, MD 21817 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i> | | | | 22. NAME AND ADDRESS OF FACILITY Maryland State Anatomy Board 655W. Baltimore St, Balto, MD 21201 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Carcinoma, Right Neck, Recurrent</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Primary Squamous Cell Carcinoma of Larynx</i> c. d. Approximate Interval Between Onset and Death <i>3 months</i> <i>12 months</i> | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Depression with Anorexia</i> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Sella</i> | | 29c. LICENSE NUMBER D 29505 | | 29d. DATE SIGNED (Month, Day, Year) 1-1-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO M. BELLOSO, M.D. 4421 BEECHWOOD PL. CRISFIELD, MD. 21817 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | | | | | |

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00407 | |
|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) LULA MAE STREIB | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 7, 1994 | | 3. TIME OF DEATH 8:45 A M | |
| 4. SOCIAL SECURITY NUMBER 216-10-4552 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-18-1910 | |
| 9a. FACILITY NAME (If not institution, give street and number) 7977 MCNELIN WAY | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SEVERN | | 9c. COUNTY OF DEATH ANNE ARUNDEL | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION SEVERN | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 7977 MCNELIN WAY | | | |
| 10f. ZIP CODE 21144 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS | | 15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) EXECUTIVE SECRETARY | | 15b. KIND OF BUSINESS/INDUSTRY W. R. GRACE RESEARCH | | | |
| 17. FATHER'S NAME (First, Middle, Last) ZENO A. FISHER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA SMITH | | | |
| 19a. INFORMANT'S NAME (Type/Print) RAYMOND E. STREIB | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7977 MCNELIN WAY SEVERN, MARYLAND 21144 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY 1-12-94 | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC UTERINE MIXED MESODERMAL SARCOMA DUE TO (OR AS A CONSEQUENCE OF): b. BOWEL OBSTRUCTION 20 TO #1. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | Approximate Interval Between Onset and Death 6 Months 1 Month | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Joseph Buscema, MD ATTENDING PHYSICIAN | | | |
| 29c. LICENSE NUMBER D25274 | | | | 29d. DATE SIGNED (Month, Day, Year) 1-10-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print) JOSEPH BUSCEMA, MD 900 CATON AVENUE, ST. AGNES HOSP., BALT, MD 21209 | | | | 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | |
| 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00408 | | | |
|--|--|---|--|--|--|--|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | |
| ELIZABETH THELMA STRAUSS | | | | MONTH DAY YEAR JANUARY 8, 1994 | | | | M | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 7. DATE OF BIRTH | |
| 216-10-7069 | | 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 89 YRS. | | MONTHS DAYS | | HOURS MIN. | | NOV. 9, 1904 | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| NORTH ARUNDEL HOSPITAL | | | | GLEN BURNIE | | | | ANNE ARUNDEL | | | |
| RESIDENCE OF DECEDENT | | | | 10c. CITY, TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | | | |
| 10a. STATE | | 10b. COUNTY | | GLEN BURNIE | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| MARYLAND | | ANNE ARUNDEL | | | | | | | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 7736 WOODSIDE TERRACE, APARTMENT T2 | | | | 21061 | | | | U.S.A. | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | | | |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | Specify: WHITE | | | | | |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | IF YES, GIVE WAR OR DATES | | Specify: | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12) | | College (1-4 or 5+) | | SEAMRESS | | | | UPHOLSTERY | | | |
| 8 | | NONE | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| WILLIAM MOODY | | | | ANNA BROWN | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| WILLIAM AUGUST STRAUSS | | | | 7736 WOODSIDE TERRACE, APT. T-2, GLEN BURNIE, MD. 21061 | | | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | DATE | | 20c. LOCATION — City or Town, State | | | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State | | GLEN HAVEN MEMORIAL PARK | | 1/12/94 | | GLEN BURNIE, MARYLAND | | | | | |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| | | | | SINGLETON FUNERAL HOME, 1 SECOND AVE., S.W., GLEN BURNIE, MD. 21061 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular accident | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| b. Atherosclerosis | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? | | | |
| | | | | | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| | | | | | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 1/8/94 | | M | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | Home | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| | | | | 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| | | | | | | | | 1/10/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| DANIEL CAMPO 615 Hammonds Ln. Balt. Md 21225 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |
| JAN 11 1994 | | | | | | | | | | | |

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00409

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CYNTHIA M. STRADWICK | | | | 2. DATE OF DEATH MONTH January DAY 4 , YEAR 1994 | | 3. TIME OF DEATH 8:40 A M | |
| 4. SOCIAL SECURITY NUMBER 218-62-6843 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 40 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 11, 1953 | |
| 9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cumberland | | 9c. COUNTY OF DEATH Allegany | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE WV | | 10b. COUNTY Mineral | | 10c. CITY, TOWN OR LOCATION New Creek | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 30 Willow Court Healy Heights | | | | 10f. ZIP CODE 26743 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 3 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Certified Paralegal | | 16b. KIND OF BUSINESS/INDUSTRY Law | | | |
| 17. FATHER'S NAME (First, Middle, Last) Russell C. Clay, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Suellen Gaiter | | | |
| 19a. INFORMANT'S NAME (Type/Print) Russell C. Clay, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 384 Keyser, WV 26726 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Potomac Memorial Gardens 1/08/94 | | 20c. LOCATION — City or Town, State Keyser, West Virginia | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian L. Smith | | | | 22. NAME AND ADDRESS OF FACILITY Rotruck-Smith Funeral Home 85 S. Main Street Keyser, WV 26726 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastasis to Brain Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Advanced Carcinoma of Lung c. Situational Depression d. | | | | | | Approximate Interval Between Onset and Death 3 months 2 year | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] MD | | | | 29c. LICENSE NUMBER D 23371 | | 29d. DATE SIGNED (Month, Day, Year) 1/4/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Qamar Zaman M.D. Suite 102 625 Kent Ave. Cumberland, MD 21502 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes in the center of the page, possibly a list or a set of instructions.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00410

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Irene Sennish</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>8</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>9:10 A M</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>271-22-5378</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>99</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>3-14-1894</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Greece</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key Medical Center</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i> | | | | 9c. COUNTY OF DEATH <i>-</i> | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>-</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <i>619 S. Ponca Street</i> | | | | 10f. ZIP CODE <i>21224</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>0</i> College (1-4 or 5+) <i>-</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>-</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Christos Christodoulou</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Maria Stergaki</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>George Stamation</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>619 S. Ponca Street, Baltimore, Md. 21224</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <i>Pine Crest Cemetery</i> | | DATE <i>1-13</i> | | 20c. LOCATION — City or Town, State <i>Lake Worth, Florida</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ann S. Matthews</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Matthews Funeral Home</i> <i>3021 Eastern Avenue, Baltimore, Md. 21224</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Dementia</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Cerebrovascular Thrombosis</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>-</i> | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>malnutrition osteoporosis</i> <i>decubitus ulcer bilateral hip fractures</i> <i>anemia</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER <i>D41955</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/8/94</i> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Rebecca Elton MD JH&C - FSKMC Balto MD 21224</i> | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

01/09/00

11/11/00

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94-0034-510
B.K.S

ITEMS: 23 PART I, 27, 28a-f, PER MFO FILM G-711 5/9/94 t.t.
FOR
1 - STATE REGISTRAR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

94 00411

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ERNEST L. THOMPSON SR. | | 2. DATE OF DEATH MONTH 01 DAY 02 YEAR 94 | | 3. TIME OF DEATH 4:21 P M | | | | | |
| 4. SOCIAL SECURITY NUMBER 220- 20- 5275 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11-28-30 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH n/a | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 322 E. 26 TH STREET | | | | 10f. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) n/a | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER | | 16b. KIND OF BUSINESS/INDUSTRY n/a | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN STANTON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EVELYN THOMPSON | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MILDRED THOMPSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 NORTH BROADWAY apt. 1, BALTIMORE, MARYLAND 21231 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA CEMETERY | | DATE | | 20c. LOCATION — City or Town, State OWINGS MILLS, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input checked="" type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 1-2-94 | | 28b. TIME OF INJURY FOUND P M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: RESIDENCE | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 322 EAST 26TH STREET BALTIMORE, MARYLAND | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) 01/03/1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00412

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) MARY H. THOMPSON | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN. 9, 1994 | | 3. TIME OF DEATH 3:46 A M | |
| 4. SOCIAL SECURITY NUMBER 244-18-6900 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-2-1919 | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Sam. Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BAITO. | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE md. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BAITO. | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2760 Kennedy Ave | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <input checked="" type="checkbox"/> College (14 or 16+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unemployed | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) ERNEST FREDRICK | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Thompson | | | |
| 19a. INFORMANT'S NAME (Type/Print) Barbara Huley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 Hellenwood Rd BAITO. Md. 21218 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cem 1/4 BAITO. Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Betts Funeral Home | | | | 22. NAME AND ADDRESS OF FACILITY 1129 N. Caroline St | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. CARDIOPULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): b. BRAINSTEM STROKE DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death 11 Minutes 10 hrs. |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Abuse of Alcohol Digoxin toxicity | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M.D. | | | | 29c. LICENSE NUMBER # 038 | | 29d. DATE SIGNED (Month, Day, Year) JAN. 9, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAURE JEANT. MACARUBBO, GOOD SAMARITAN HOSPITAL | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John Benveniste | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00413 | |
|--|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Gordon L. Taylor Sr.</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>8</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>1620</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>220-30-1649</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>58</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>4/17/1935</i> | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Harbor Hospital Center</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>balto. City, Md.</i> | | 9c. COUNTY OF DEATH ----- | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY ----- | | 10c. CITY, TOWN OR LOCATION <i>Balto. City,</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>1110 S. Carey St,</i> | | 10f. ZIP CODE <i>21223</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>3rd, Grade</i> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Huckster</i> | | 15b. KIND OF BUSINESS/INDUSTRY <i>Own Bus,</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>James Taylor</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mildred -- Horlacher</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Gordon L. Taylor, Jr.</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1110 S. Carey St. Balto. Md. 21223</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Glen Haven mem. Pk. 1/12/94</i> | | DATE <i>1/12/94</i> | | 20c. LOCATION — City or Town, State <i>Glen Burnie, Md.</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Samuel A. Taylor</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Balto. Md. 21230 McCully Funeral Home, 130 E. Fort ave</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio Pulmonary arrest</i> | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| a. <i>Chronic blood loss</i> | | | | | | | |
| b. <i>GI bleed.</i> | | | | | | | |
| c. <i>GI bleed.</i> | | | | | | | |
| d. <i>GI bleed.</i> | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes, Peripheral vascular disease, Cerebral vascular accident, COPD</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) <i>11/20/93</i> | | 28b. TIME OF INJURY <i>M</i> | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard J. Osorio</i> | | | | 29c. LICENSE NUMBER <i>Harbor Hosp.</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/8/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Richard J. Osorio</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 10 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John J. ...</i> | | | |

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1961 OCT 10

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00414

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA W. WEBSTER | | | | 2. DATE OF DEATH MONTH 01 DAY 06 YEAR 94 | | 3. TIME OF DEATH 8:05 P.M. | |
| 4. SOCIAL SECURITY NUMBER 217-24-2410 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 63 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-18-30 | |
| 8a. FACILITY NAME (If not institution, give street and number) 2227 WHEATLEY ROAD | | | | 8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 8c. COUNTY OF DEATH MD | |
| 9a. STATE MD | | 9b. COUNTY BALTO | | 9c. CITY, TOWN OR LOCATION BALTO | | 9d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10a. STREET AND NUMBER 2227 WHEATLY DR. APT 104 | | | | 10b. ZIP CODE 21207 | | 10c. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 17. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) NORTH WARREN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) RUBY GEE | | | |
| 19a. INFORMANT'S NAME (Type/Print) KENNEL WEBSTER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 N. LAKEWOOD AVE BALTO, MD 21213 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, hospital, or other place) GARRISON FOREST VETERAN 11294 | | 20c. LOCATION — City or Town, State OWINGS MILLS, MD | | 20d. DATE 11294 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H WEST 4300 WABASH AVE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO INQUIRY |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 1-7-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mario F. Golle Jr. M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00415 | |
|--|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Oda R. Wilhelm</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>January 7 1994</i> | | 3. TIME OF DEATH <i>4:20 A M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>215 07 2633</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>82</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year) <i>9/13/1911</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH <i>--</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>--</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>1404 Weldon Place South</i> | | | | 10f. ZIP CODE <i>21211</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>Accounts Payable</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Department Store</i> | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) <i>George W. Kates</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Alice N. Gosnell</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Charles M. Wilhelm</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1404 Weldon Place South, Baltimore 21211 Maryland</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt. Pleasant Cemetery 1/10 Gamber, Maryland</i> | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lynn Burgee-Henss</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Burgee-Henss Funeral Home 21211 3631 Falls Road, Baltimore Maryland</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>intraventricular hemorrhage</i> | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's Dementia</i> <i>Rheumatoid Arthritis</i> <i>Osteoporosis</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John N. House Officer</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>1/7/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ALI NIAK - Sinai Hospital of Baltimore</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 11 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John N. House Officer</i> | | | |

218012

11/11/11

11/11/11

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) CHARLES T. WILLIAMS JR. | | | | 2. DATE OF DEATH MONTH 01 DAY 07 YEAR 94 | | 3. TIME OF DEATH 5:10 A. M. | |
| 4. SOCIAL SECURITY NUMBER 216-03-4761 | | 5. SEX XX M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 87 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12-19-06 | |
| 9a. FACILITY NAME (If not institution, give street and number) ROLAND PARK PLACE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEASED | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION TOWSON BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 830 WEST 40TH STREET APT. 2351 1324 DULANEY VALLEY ROAD | | | | 10f. ZIP CODE 21211 21204 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WORLD WAR II | | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 YEARS | | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER, INVESTMENT BANKER | | 16b. KIND OF BUSINESS/INDUSTRY INVESTMENT BANKING | | | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES T. WILLIAMS SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) WILLIE ASHTON | | | |
| 19a. INFORMANT'S NAME (Type/Print) DAVID MCI. WILLIAMS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 CHESTNUT RIDGE DR., LUTHERVILLE, MD. 21093 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR GROVE CEMETERY 1-10 | | 20c. LOCATION — City or Town, State PORTSMOUTH, VA. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS 4905 YORK ROAD, BALTIMORE, MD. 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. PNEUMONIA - ASPIRATION | | | | Approximate interval Between Onset and Death 5 DAYS | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. CVA | | | | 2 YRS | |
| | | c. DIABETES | | | | 20 YRS | |
| | | d. HYPERTENSION | | | | 11 | |
| | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D10678 | | 29d. DATE SIGNED (Month, Day, Year) 01-07-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DANIEL G. SAPIR, M.D., 9 EAST CHASE STREET, BALTIMORE, MD. 21202 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00417

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) NOAH J. WALSTON | | | | 2. DATE OF DEATH MONTH 01 DAY 03 YEAR 94 | | 3. TIME OF DEATH 0:40 AM | |
| 4. SOCIAL SECURITY NUMBER 213-70-0810 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 42 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-21-52 | |
| 9a. FACILITY NAME (If not institution, give street and number) Church & Home Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto. | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Balto. | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 400 N. Belnord Ave | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) (12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Noah Walston | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Georgia Ann Marie Cherry | | | |
| 19a. INFORMANT'S NAME (Type/Print) Sherie Walston | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Belnord Ave 21224 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star | | 20c. LOCATION — City or Town, State Calverton Md. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeff Miller | | | | 22. NAME AND ADDRESS OF FACILITY Sett Miller F/H 1639 N. Broadway | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Endocarditis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 31 days |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acquired Immune Deficiency Syndrome (AIDS) | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Samuel Mahmood MD. | | | | 29c. LICENSE NUMBER D44378 | | 29d. DATE SIGNED (Month, Day, Year) 1/3/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MANSON MAHMOOD MD. 2806 VILLAGE DRIVE AVENEL NJ 07001 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John Bennewander | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL HOME OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11000 42

STEVENSON

5000 1000

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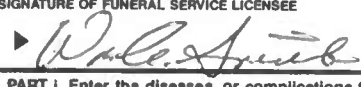
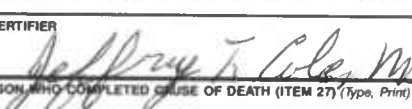

ER # 1838510

U# 453928

94 00418

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) a/k/a Addie Lois Wheeler | | | | 2. DATE OF DEATH MONTH 1 DAY 8 YEAR 94 | | 3. TIME OF DEATH 3:PM | |
| ADDIE L WHEELER | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 246-30-7694 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 65 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 2/10/28 | | 8. BIRTHPLACE (State or Foreign Country) North Carolina | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH n/a | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Ellicott City | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 760 Oella Avenue | | | | 10f. ZIP CODE 21043 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dietary Staff | | 16b. KIND OF BUSINESS/INDUSTRY Howard Co. Gov't. Dept. of Corrections | | | |
| 17. FATHER'S NAME (First, Middle, Last) (unknown) Storey | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lily Gertrude Futtrell | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Robert L. Wheeler, Sr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 760 Oella Ave., Ellicott City, MD 21043 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Pk. 1-12-94 ElkrIDGE, MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A. Ellicott City, Maryland 21043 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death 1 hr. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): | | | | | 5 years |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | 29c. LICENSE NUMBER 121512 | | 29d. DATE SIGNED (Month, Day, Year) 1/8/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED FORM OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

3. 28. 11. 20



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00419

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEASED'S NAME (First, Middle, Last) Walter L. WILSON | | | | 2. DATE OF DEATH MONTH DAY YEAR January 9, 1994 | | 3. TIME OF DEATH 11:47 p m | |
| 4. SOCIAL SECURITY NUMBER 215-09-2337 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-3-1920 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Md | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 4406 Anntana Ave. | |
| 10f. ZIP CODE 21206 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.2 | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman | | 16b. KIND OF BUSINESS/INDUSTRY Lord Baltimore Laundry | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Wilson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie D. Mongereth | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Kathy L. Wilson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4406 Anntana Ave. Balto., Md 21206 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Mem. Cem. 1/11/94 Balto., Md | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gay S. Smith | | | | 22. NAME AND ADDRESS OF FACILITY Hantley Miller Funeral Home 7527 Hanford Rd. Balto., Md 21234 | | | |
| 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End stage congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): c. Renal failure DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic valve replacement | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Khalid Malik | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/9 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Khalid Malik M.D. 9000 Franklin Square Drive, Baltimore, MD 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE John Wilson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21400 40

21400 40

21400 40

21400 40

21400 40

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00420

| | | | | | | | | | | |
|---|--|--|---------------------------------|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM R WEBER | | | | 2. DATE OF DEATH MONTH JANUARY DAY 7 YEAR 1994 | | | | 3. TIME OF DEATH 8:40 a.m. | | |
| 4. SOCIAL SECURITY NUMBER 215-16-9360 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-17-1922 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH ----- | | |
| 10a. STATE Md | | | 10b. COUNTY Baltimore | | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 5513 Summenfield Ave. | | | | 10f. ZIP CODE 21206 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor | | | 16b. KIND OF BUSINESS/INDUSTRY Warehouse | | | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Michael A. Rathel | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3307 Hiss Ave. Balto., Md. 21234 | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Wood Lawn Cem 1/11/94 Balto., Md | | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gray D. Smith | | | | 22. NAME AND ADDRESS OF FACILITY Hartley Miller Funeral Home 7527 Hanford Rd. Balto., Md. 21234 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF): b. Pericardial effusion DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death 12 hrs 1 week | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | |
| | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Laurence Gardner MD | | | | 29c. LICENSE NUMBER 19693 | | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Laurence Gardner Tower 110 GOW WALK ST BALTIMORE | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 11 1994 | | | | 32. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05/09/80

MEMORANDUM

TO : [illegible]

FROM : [illegible]

24th July 1980

2

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00421

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edna V. Williams | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 6, 1994 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 213-10-6102 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 8. AGE (In yrs. last birthday) 88 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 12/14/1905 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1706 S.Charles St. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Balto.City,Md. | | 9c. COUNTY OF DEATH ----- | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY ----- | | 10c. CITY, TOWN OR LOCATION Balto.City,Md. | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1706 S.Charles St. | | | | 10f. ZIP CODE 21230 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 8th.Grade none | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Bowen, Law Firm | | | |
| 17. FATHER'S NAME (First, Middle, Last) Charles E. Voll | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary ---- Downy | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr.Donald R.Williams | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12700 Cherrywood Lane, Bowie,Md.20715 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross X Cemt.1/10/94 | | 20c. LOCATION - City or Town, State A.A.Co.Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald A. Mayhew</i> | | | | 22. NAME AND ADDRESS OF FACILITY Balto.Md.21230 McCully Funeral Home,130 E.Fort Ave | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Acute Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | b. <i>Hypertensive Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald A. Mayhew</i> | | | | 29c. LICENSE NUMBER D09220 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1225 South Charles St - Baltimore, Md 21230 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | |

15000 42

15000 42

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00422

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM | | | | 2. DATE OF DEATH MONTH 01 DAY 08 YEAR 94 | | | | 3. TIME OF DEATH 4:51 A.M. | |
| 4. SOCIAL SECURITY NUMBER 213-28-3230 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 61 YRS. | | IF UNDER 1 YEAR MONTHS 00 DAYS 00 | | IF UNDER 24 HRS. HOURS 00 MIN. 00 | |
| 7. DATE OF BIRTH (Month, Day, Year) 5-19-32 | | | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 2823 RIGGS AVE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2823 Riggs Ave | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR OATES 53-57 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) None | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance | | | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) William Weeden | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH Hemminger | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Weeden | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2823 Riggs Ave Balto, MD 21216 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carrison Forest 1/3/94 | | | | 20c. LOCATION — City or Town, State Cumms Mills, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Walter M. Callow | | | | 22. NAME AND ADDRESS OF FACILITY 3405 W. Franklin St Baltimore, MD 21229 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CANCER OF PANCREAS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension | | | | | | | | Approximate Interval Between Onset and Death | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO INQUIRY | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute M.D. | | | | 29c. LICENSE NUMBER O.C.M.E. | | | | 29d. DATE SIGNED (Month, Day, Year) 1-8-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 10 1994 | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00423

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Julian Edward Anderson | | | | 2. DATE OF DEATH MONTH DAY YEAR January 10 1994 | | 3. TIME OF DEATH 6:00 PM | |
| 4. SOCIAL SECURITY NUMBER 472-20-2358-A | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) August 5, 1924 | |
| 8. BIRTHPLACE (State or Foreign Country) Minnesota | | | | 9. COUNTY OF DEATH Baltimore | | | |
| 10. FACILITY NAME (If not institution, give street and number) 222 Tyrone Circle | | | | 11. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | |
| 12. RESIDENCE OF DECEDENT | | | | 13. COUNTY OF DEATH | | | |
| 14a. STATE Maryland | | 14b. COUNTY Baltimore | | 14c. CITY, TOWN OR LOCATION Baltimore | | 14d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 15. STREET AND NUMBER 222 Tyrone Circle | | | | 16. ZIP CODE 21212 | | 17. CITIZEN OF WHAT COUNTRY? United States | |
| 18. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II | | 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 21. RACE — American Indian, Black, White, etc. Specify: White | |
| 22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrator | | 24. KIND OF BUSINESS/INDUSTRY American Red Cross | | | |
| 25. FATHER'S NAME (First, Middle, Last) Ole Edward Anderson | | | | 26. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Nordgulen | | | |
| 27. INFORMANT'S NAME (Type/Print) Mary Lee Baker Anderson | | | | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Tyrone Circle Baltimore, MD 21212 | | | |
| 29. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory 1/11/94 | | 31. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert M. Kratz | | | | 33. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212 | | | |
| 34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) → <u>Acute Myocardial Infarction/Coronary Artery Disease</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>With Coronary Insufficiency</u> c. d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| 35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Cancer of Colon</u> | | | | | | | |
| 36. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 37. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 38. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 40. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 41. DATE OF INJURY (Month, Day, Year) | | 42. TIME OF INJURY M | | 43. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 44. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 45. DESCRIBE HOW INJURY OCCURRED | | | |
| 46. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 47. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 48. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 49. SIGNATURE AND TITLE OF CERTIFIER Charles F. O'Donnell, M.D. | | | | 50. LICENSE NUMBER D-09383 | | 51. DATE SIGNED (Month, Day, Year) 1/11/94 | |
| 52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles F. O'Donnell, M.D. - 408 N. ... - Baltimore, MD 21210 | | | | | | | |
| 53. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 54. REGISTRAR'S SIGNATURE John ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

28400 42

COMMUNICATIONS

SECTION

10/1/54

10/1/54

10/1/54

10/1/54

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00424

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MAMIE W ANTHONY | | | | 2. DATE OF DEATH MONTH 01 DAY 09 YEAR 94 | | 3. TIME OF DEATH 08:16 AM M | |
| 4. SOCIAL SECURITY NUMBER 141-16-3996 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-22-15 | |
| 8. BIRTHPLACE (State or Foreign Country) Berryville, Va. | | | | 9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION | | 9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE | |
| 9c. COUNTY OF DEATH A.A. COUNTY | | | | 10a. STATE Md. | | 10b. COUNTY | |
| 10c. CITY, TOWN OR LOCATION Odenton | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1841 Huntover Dr. | | | | 10f. ZIP CODE 21113 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Williams | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joan Elliott | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1841 Huntover Dr. Odenton, Maryland 21113 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenwood Cemetery 1/14/94 | | 20c. LOCATION — City or Town, State Pleasantville, N.J. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY William C. Brown Community F.H. 1206 W. North Ave. Balto. Md. 21217 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>INTRACRANIAL ANEURYSM</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HYPERTENSION</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER 019991 | | 29d. DATE SIGNED (Month, Day, Year) 1/11/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID ROSE, M.D./200 HOSPITAL DRIVE, SUITE 500/GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 0055

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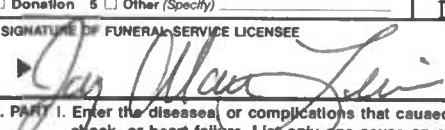

4

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00425

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) IDA ASKINOSIE | | | | 2. DATE OF DEATH MONTH DAY YEAR 1 - 7 - 1994 | | 3. TIME OF DEATH 5:25 A M | |
| 4. SOCIAL SECURITY NUMBER 151-24-2182 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 97 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT 17, 1896 | |
| 9a. FACILITY NAME (If not institution, give street and number) LEVINDALE | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2500 W BELVEDERE AVE, APT. 817 | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY AT HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last) MOSHE AARON MARKOWITZ | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) RACHEL | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS ROSLYN COHEN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3916 SOUTHERN CROSS DR BALTO MD 21207 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____ | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LIBERTY PARK 1/9/94 | | 20c. LOCATION — City or Town, State RANDALLSTOWN MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERTOWN RD. BALTO., MD 21215 | | | |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio - pulmonary arrest DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF): c. Atherosclerotic Cardiac disease DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gangrenous Left Foot Diabetes mellitus | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Consuelo Alvarez MD | | | | 29c. LICENSE NUMBER D 44902 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00426

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Rita MARY BAKER | | | | 2. DATE OF DEATH MONTH 1-10 DAY 94 YEAR | | 3. TIME OF DEATH 7:23 P M | |
| 4. SOCIAL SECURITY NUMBER 214-14-7043 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) MAY 9, 1917 | |
| 8. BIRTHPLACE (State or Foreign Country) BALTO. MD. | | | | 9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE MARYLAND | | | |
| 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 4901 LASALLE AVENUE | | | |
| 10f. ZIP CODE 21206 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BOOK KEEPER | | 16b. KIND OF BUSINESS/INDUSTRY HOSPITAL | | | |
| 17. FATHER'S NAME (First, Middle, Last) CLARENCE MORNINGSTAR | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET HUGHES | | | |
| 19a. INFORMANT'S NAME (Type/Print) JEANNE SCELSI | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4901 LASALLE AVENUE BALTIMORE, MD. 21206 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MORELAND MEMORIAL 1/14/94 | | 20c. LOCATION — City or Town, State BALTIMORE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN E. DOLAN | | | | 22. NAME AND ADDRESS OF FACILITY LEONARD J. RUCK INC. 5305 HARFORD ROAD BALTIMORE, MD. 21214 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Left ventricular dysfunction DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease coronary artery disease peripheral vascular disease | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE NOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ritamarie Moscola MD | | | | 29c. LICENSE NUMBER D 35248 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/93 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Ritamarie Moscola 9000 Franklin Square Dr. Baltimore, Maryland 21237 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE John E. Dolan | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00427 | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|---|--|---|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | | | | | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) YVONNE BYRD | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 10, 1994 | | | | 3. TIME OF DEATH 7:22 a.m. | | | | | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-38-6392 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 11-18-40 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY, MD | | | | 9c. COUNTY OF DEATH n/a | | | | | | | | | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY n/a | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | | | |
| 10e. STREET AND NUMBER 1528 N. PATTERSON PARK AVENUE | | | | 10f. ZIP CODE 21213 | | | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | | | | | | | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 11 TH College (1-4 or 8+) 11 TH | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | | | 16b. KIND OF BUSINESS/INDUSTRY n/a | | | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) CLARENCE TRICE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) VARA MITCHENER | | | | | | | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) TONDRA BRUTON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1528 N. PATTERSON PARK AVENUE, BALTIMORE, MD #13 | | | | | | | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL GARDENS 01-15 RANDALLSTOWN, MD | | 20c. LOCATION — City or Town, State | | | | | | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE See V. Holland | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.— 1101 E. NORTH AVENUE | | | | | | | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis b. Bowel perforation c. Lupus / Scleroderma d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | | | | | Approximate Interval Between Onset and Death 1 day 2 days 15 years | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | | | | | | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER J. H. H. | | 29c. LICENSE NUMBER 55780 | | 29d. DATE SIGNED (Month, Day, Year) 1/11/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N. Wolfe St JHH Balt., Md 21287 | | | | | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE J. H. H. | | | | | | | | | | | | | | | | | |

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00428

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Donald Michael Barrick, Sr. | | | | 2. DATE OF DEATH MONTH 1 DAY 7 YEAR 94 | | 3. TIME OF DEATH 445 P M | |
| 4. SOCIAL SECURITY NUMBER 579-40-9742 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) November 21, 1931 | |
| 9a. FACILITY NAME (If not institution, give street and number) 20 Stream Run Ct. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Timonium | | 9c. COUNTY OF DEATH Balto. | |
| 10a. STATE Maryland | | | | 10b. COUNTY Balto. | | 10c. CITY, TOWN OR LOCATION Timonium | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 20 Stream Run Ct. | | | |
| 10f. ZIP CODE 21093 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 14 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Physician | | 16b. KIND OF BUSINESS/INDUSTRY Medical | |
| 17. FATHER'S NAME (First, Middle, Last) George Barrick | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Dora | | | |
| 19a. INFORMANT'S NAME (Type/Print) Donald M. Barrick, Jr. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2068 Royal Farm Ct. Bel Air, Md. 21015 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns 1/11/94 | | 20c. LOCATION — City or Town, State Timonium, Md. | | 20d. DATE 1/11/94 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY 1050 York Rd. 21204 Ruck Towson Funeral Home, Inc. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer. | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home | | | | 28e. DESCRIBE HOW INJURY OCCURED | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Eric Fisher MD | | | | 29c. LICENSE NUMBER D25331 | | 29d. DATE SIGNED (Month, Day, Year) 1/9/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eric F. Fisher M.D. 1900 East Northern Pkwy 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 8 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00429

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Margaret Chlan | | | | 2. DATE OF DEATH MONTH DAY YEAR 11/8/94 | | 3. TIME OF DEATH 11:50 P.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 216-01-2604 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) February 20, 1916 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | | | 9c. COUNTY OF DEATH N/A | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 116 West University Parkway | | | | 10f. ZIP CODE 21218 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrative Assistant | | 15b. KIND OF BUSINESS/INDUSTRY Chemical Company | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Francis Charles Chlan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Prager | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Francis C. Chlan | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9214 Adelaide Drive Bethesda Maryland 20817 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park Cemetery 1/12 | | 20c. LOCATION — City or Town, State Baltimore Maryland | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis Stephen Xenakis M00640 | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore Maryland 21212 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. MESENTERIC VEIN THROMBOSIS c. ISCHEMIC BOWEL d. GIBBS ON LIVER. Error found | | | | | | | | Approximate interval between Onset and Death 2 days 8 days 8 days | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cirrhosis of liver, Congestive heart failure, Thrombocytopenia, Respiratory failure, DM, gastritis, GI bleed | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER P.G.Y.-J | | | | 29c. LICENSE NUMBER 243-8946-F9 | | 29d. DATE SIGNED (Month, Day, Year) 11/8/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RANJAN PAUL, UMH, 201E, UNIV PKWY, BALTIMORE, MD-21218 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00430

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Edward Holmes Copenhaver | | | | 2. DATE OF DEATH MONTH 01 DAY 05 YEAR 94 | | 3. TIME OF DEATH 7:55 A M | |
| 4. SOCIAL SECURITY NUMBER 212-09-1363 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 88 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 09/21/1905 | | 8. BIRTHPLACE (State or Foreign Country) Baltimore | |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland Masonic Homes | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Cockeysville | | 9c. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Cockeysville | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 300 International Circle | | | |
| 10f. ZIP CODE 21030-1359 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) _____ | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor | | 16b. KIND OF BUSINESS/INDUSTRY Acme Stores | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Holmes Copenhaver | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Estelle Houck | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mildred Davis (sister) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3523 Glenwood Rd Baltimore, Maryland 21220 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oaklawn Cemetery January 7, 1994 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | 20d. DATE January 7, 1994 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas Joseph Bozek | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home Inc. 6500 York Rd. Baltimore, MD 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Prostatic CA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. _____ DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OCA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dr. M. Bozek | | | | 29c. LICENSE NUMBER 105488 | | 29d. DATE SIGNED (Month, Day, Year) 1-5-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | | | | |
| 32. REGISTRAR'S SIGNATURE John A. ... | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR AT THE HOME OF THE DECEASED: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00431

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Sarah Cooper | | | | 2. DATE OF DEATH MONTH 1 DAY 07 YEAR 94 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 214 18 3294 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 2-29-1900 | |
| 9a. FACILITY NAME (If not institution, give street and number) 2902 Baker Street | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE Md. | | | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 2902 Baker Street | | 10f. ZIP CODE 21216 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | | | 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | 17. FATHER'S NAME (First, Middle, Last) | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Cooper | | | | 19a. INFORMANT'S NAME (Type/Print) Frances E. Royster | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2902 Baker Street Balto., Md. 21216 | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus | | 20c. LOCATION — City or Town, State 1/12 Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i> | | | | 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. Advanced Age DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. J. Roberts, M.D.</i> | | | | 29c. LICENSE NUMBER D2146K | | 29d. DATE SIGNED (Month, Day, Year) 1-10-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 300 Army PLAZA Suite 3F Balto. Md 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Swenson-Pendse</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00432 | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | | | 3. TIME OF DEATH | | | |
| Cornelius COLE | | | | January 5, 1994 | | | | 8:43 A M | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign Country) | | | |
| 215 14 9265 | | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 73 YRS. | | 12-24-20 | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | |
| Franklin Square Hospital | | | | Rosedale/Essex | | | | Baltimore County | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | | | |
| MD | | Balto Co | | Baltimore | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| Ivy Hall Ger. Cnt 1300 Windlass Drive | | | | 21220 | | | | | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? | | 14. RACE — American Indian, Black, White, etc. | | | | | |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| 20a. METHOD OF DISPOSITION | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | DATE | | 20c. LOCATION — City or Town, State | |
| 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | |
| Ronald Wade, Dir | | | | State Anatomy Board 655W. Baltimore St, Balto, MD 21201 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate interval Between Onset and Death | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | | |
| a. Massive Hemoptysis DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| b. Bilateral advanced cancer lungs DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| Adult onset diabetes mellitus Atherosclerotic cardiovascular disease Hypertension | | | | | | | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | | | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK? | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | | | M | | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | | |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | Malika Wasserman | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) | |
| | | | | | | | | D-38754 | | January 5, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | MALIKA WASSERMAN, 100. N. BROADWAY, BALTIMORE, MD - 21231 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |
| JAN 12 1994 | | | | [Signature] | | | | | | | |

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Full on 11/1/68

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2000 11/1/68

94 00433

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Lenora Marie Croom</i> | | | | 2. DATE OF DEATH MONTH <i>01</i> DAY <i>08</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>7:20 PM</i> | |
| 4. SOCIAL SECURITY NUMBER <i>215124265</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>72</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>08/16/21</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Good Samaritan Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i> | | 9c. COUNTY OF DEATH <i>MARYLAND</i> | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>5608 Lothian Road</i> | | | | 10f. ZIP CODE <i>21212</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>12th grade</i> | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | 15b. KIND OF BUSINESS/INDUSTRY --- | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Enrick Burger Thistel</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Emma Thau</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Charles R. Werner</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5608 Lothian Road Baltimore, MD 21212</i> | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Parkwood Cemetery</i> | | DATE <i>1/11/94</i> | | 20c. LOCATION — City or Town, State <i>Baltimore, MD</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286</i> | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. left lobar pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>① Recurrent Cancer of the tongue with residual tumor involving the right carotid artery.</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other (Specify) | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>JOHN MIAH M.D.</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>01/08/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JOHN MIAH (M.D.) GOOD SAMARITAN HOSPITAL</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 12 1994</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 00434

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Dorothy Jane Collier | | | | 2. DATE OF DEATH MONTH 1 - DAY 9 - YEAR 94 | | 3. TIME OF DEATH 10:30 AM | |
| 4. SOCIAL SECURITY NUMBER 212-184005 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/16/20 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH Baltimore | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore | |
| 10c. CITY, TOWN OR LOCATION Towson | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 2300 Dulaney Valley Road | |
| 10f. ZIP CODE 21204 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3 yrs | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RN | | 16b. KIND OF BUSINESS/INDUSTRY Blue Cross | |
| 17. FATHER'S NAME (First, Middle, Last) Cecil Tredway Hipkins | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Evelyn Crumlich | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret Plume | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1624 A Michelle Ct. Forest Hill, MD 21050 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 1/10/94 | | 20c. LOCATION — City or Town, State Catonsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Basal obstruction</u> b. <u>LYMPHOMA</u> c. d. Approximate interval between Onset and Death 2 wks | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>SIP ACUTE MYOCARDIAL INFARCTION</u> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D05643 | | 29d. DATE SIGNED (Month, Day, Year) 1-9-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kendall R. Faulkner, M.D., 2300 Dulaney Valley Road, Towson, Maryland 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00435

| | | | | | | | | |
|---|--|--|--|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LOUISE C. COVINGTON | | | | 2. DATE OF DEATH MONTH 01 DAY 8 YEAR 1994 | | 3. TIME OF DEATH 4:45 P M | | |
| 4. SOCIAL SECURITY NUMBER 214-03-7756-B | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 5-11-07 | | 8. BIRTHPLACE (State or Foreign Country) Westpoint, Va. | |
| 9a. FACILITY NAME (If not institution, give street and number) Liberty Medical | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH | | |
| RESIDENCE OF DECEDENT | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 2525 Belvedere Ave. | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Saleswoman | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Phillip Christian | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Fatie Banks | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret Williams | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 Westwood Ave. Baltimore, Maryland 21216 | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem. 1-17 | | 20c. LOCATION — City or Town, State Owings Mills, Md. | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY William C. Brown Community F.H. 1206 W. North Ave. Balto. Md. 21217 | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INSULIN DEPENDENT DIABETES MELLITUS CARCINOMA OF BREAST | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suiicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER PHYSICIAN <i>[Signature]</i> | | | | 29c. LICENSE NUMBER D 42723 | | 29d. DATE SIGNED (Month, Day, Year) 11/8/94 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AVVERAHLI M HARRIS 3745 TOTT FORD STREAM RD MD 21236 | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

36100 02

RECEIVED
JAN 10 1964

RECEIVED
JAN 10 1964

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00436

| | | | | | | | | | | | |
|---|--|--|--|---|---|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LAVEATA CORPREW | | | | 2. DATE OF DEATH MONTH 1 DAY 10 YEAR 94 | | 3. TIME OF DEATH 6:25 AM | | | | | |
| 4. SOCIAL SECURITY NUMBER 215 90 0676 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 31 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/11/62 | | 8. BIRTHPLACE (State or Foreign Country) UNK. Md | | | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO. MD 21215 | | | | 9c. COUNTY OF DEATH BALTO. CITY | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE Md | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Balto | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3906 Groveland Ave apt c | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unknown | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Bernard Corprew | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ernestine Goodwin | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ernestine Goodwin | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3906 Groveland Ave Apt-C Balto, Md 21215 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 11/14/94 | | | 20c. LOCATION — City or Town, State Balto, md | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale Marsh | | | | 22. NAME AND ADDRESS OF FACILITY March A H - West 4300 Wabash Ave | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Auto Immune Deficiency Syndrome b. Intravenous Drug Use c. d. | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Frederick W. Randolph, MD | | | | | | 29c. LICENSE NUMBER D19085 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | | | | | | | | |
| REGISTRAR'S SIGNATURE John Andrew Riddle | | | | | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00437

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LOUIS Anthony Canavino | | | | 2. DATE OF DEATH MONTH 1 DAY 8 YEAR 94 | | 3. TIME OF DEATH 3:45 a | | | | | |
| 4. SOCIAL SECURITY NUMBER 045-20-8843 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) November 4, 1926 | | 8. BIRTHPLACE (State or Foreign Country) Connecticut | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | | | 9c. COUNTY OF DEATH Balto. | | | |
| 10a. STATE Maryland | | 10b. COUNTY Balto. | | 10c. CITY, TOWN OR LOCATION Towson | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1000 East Joppa Rd. | | | | 10f. ZIP CODE 21286 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Captain | | 16b. KIND OF BUSINESS/INDUSTRY Tug Boat | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Michael Canavino | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Connie Frate | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Frank Gallo | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Grace St. - New Canaan, Conn. 06840 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns 1/11/94 Timonium, Md. | | | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY 1050 York Rd. 21204 Ruck Towson Funeral Home, Inc. | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Bilateral Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Malignant Atrial Effusion DUE TO (OR AS A CONSEQUENCE OF): d. Squamous Cell Carcinoma | | | | | | | | Approximate interval Between Onset and Death 4 days 14 months | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER William D. McConnell M.D. | | | | 29c. LICENSE NUMBER D42129 | | 29d. DATE SIGNED (Month, Day, Year) Jan 8, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William D. McConnell 500 W. University Baltimore MD 21210 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

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ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-707 1/27/94 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00438

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|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JULIO CESAR VAZQUEZ DEJESUS | | | | 2. DATE OF DEATH MONTH 01 DAY 10 YEAR 94 | | 3. TIME OF DEATH 2:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER 582-63-4061 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 29 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct. 21, 1964 | |
| 8. BIRTHPLACE (State or Foreign Country) Puerto Rico | | | | 9a. FACILITY NAME (If not institution, give street and number) 105 N. AMITTY STREET | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Glen Burnie | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 418 Secluded Post Circle, Apt. L | | | | 10f. ZIP CODE 21061 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Puerto Rican | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Clerk | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk | | 16b. KIND OF BUSINESS/INDUSTRY Grocery | | | |
| 17. FATHER'S NAME (First, Middle, Last) Julio Vazquez Rivera | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Paulido DeJesus DeJesus | | | |
| 19a. INFORMANT'S NAME (Type/Print) Miguel Angel Vazquez DeJesus | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Hideaway Loop Apt. E, Glen Burnie, MD 21061 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cementaria Municipal de Juana Diaz | | 20c. DATE Jan 15, 1994 | | 20d. LOCATION — City or Town, State Juana Diaz, Puerto Rico | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy., S.E. Glen Burnie, MD 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → NARCOTIC INTOXICATION | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| 23. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ALLEY/105 N. AMITTY ST. | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) UNKNOWN | | 28b. TIME OF INJURY UNKNOWN | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) UNKNOWN | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) UNKNOWN | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/11/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark F. Golis Jr. MD 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00439

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|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) VERNON DRAKE | | | | 2. DATE OF DEATH MONTH 01 DAY 06 YEAR 94 | | 3. TIME OF DEATH 4:45 p.m. | | | |
| 4. SOCIAL SECURITY NUMBER 217-26-5233 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 17, 1929 | | 8. BIRTHPLACE (State or Foreign Country) N. Carolina | |
| 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, MD. | | | 9c. COUNTY OF DEATH Baltimore Co., MD | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER 6210 Norvo Rd. | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 11 yrs. | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Organist | | | 16b. KIND OF BUSINESS/INDUSTRY Various Churches | | |
| 17. FATHER'S NAME (First, Middle, Last) Vander Drake | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Blackwell | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Iolas Drake | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6210 Norvo Rd. Baltimore, MD. 21207 | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Entombment | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | | DATE 1/11 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ernest R. Perry Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Balto., MD. 21215 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RESPIRATORY FAILURE (ARREST) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST END STAGE LUNG CANCER PNEUMONITIS | | | | | | | Approximate Interval Between Onset and Death | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Co PD | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Raymond A. Nezel MD. PA | | 29c. LICENSE NUMBER D34184 | | 29d. DATE SIGNED (Month, Day, Year) 01-06-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7801 YORK RD #300, Towson MD 21204 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | 32. REGISTRAR'S SIGNATURE <i>Jack Sanborn-Rudolph</i> | | | | | | |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00440

| | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--|--|---------------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Francis W. Dix | | | | 2. DATE OF DEATH MONTH January DAY 10 YEAR 1994 | | 3. TIME OF DEATH 03 38 M | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 214-03-0775 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 92 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb 8, 1901 | | 8. BIRTHPLACE (State or Foreign Country) Washington DC | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH Baltimore City | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore County | | 10c. CITY, TOWN OR LOCATION Villa Nova | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 7201 Rockridge Rd. | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plumber | | 16b. KIND OF BUSINESS/INDUSTRY Gordon H. McKewin Co. | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edgar Dix | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Minnis | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Louise Stinchcomb | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7201 Rockridge Rd. Baltimore, MD 21207 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lorraine Park Cemetery 1-13-94 | | DATE Woodlawn, Maryland | | 20c. LOCATION — City or Town, State | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE John K. Ayers | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. myocardial infarct DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate interval Between Onset and Death 2 days | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia hypertension | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER Medical Intern | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) January 10, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sam Sencillo Sinai Hospital | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE John Sencillo | | | | | | | | | | | |

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00441

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elizabeth Dulany | | | | 2. DATE OF DEATH MONTH 1 DAY 6 YEAR 1994 | | 3. TIME OF DEATH 9:00 a.m. | |
| 4. SOCIAL SECURITY NUMBER 215-03-3545 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9 17 1910 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. FACILITY NAME (If not institution, give street and number) Sagra Road 5627 | | 10. CITY, TOWN OR LOCATION OF DEATH Baltimore | |
| 11. RESIDENCE OF DECEDENT | | | | 12. COUNTY Maryland | | 13. CITY, TOWN OR LOCATION Baltimore | |
| 14. STATE Maryland | | | | 15. STREET AND NUMBER Sagra Road 5627 | | 16. ZIP CODE 21239 | |
| 17. CITIZEN OF WHAT COUNTRY? United States | | | | 18. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 19. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 20. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 22. RACE — American Indian, Black, White, etc. Specify: White | |
| 23. DECEDENT'S EDUCATION (Specify only highest grade completed) 6 Elementary/Secondary (0-12) College (1-4 or 5+) | | 24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home maker | | 25. KIND OF BUSINESS/INDUSTRY Domestic | | | |
| 26. FATHER'S NAME (First, Middle, Last) Joseph Kozlowski | | | | 27. MOTHER'S NAME (First, Middle, Maiden Surname) Apolonia Grozinska | | | |
| 28. INFORMANT'S NAME (Type/Print) Joseph Dulany | | | | 29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fourth Ave. 3006 Balto., Md. 21239 | | | |
| 30. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) St Stanislaus | | 32. DATE 1/10 | | 33. LOCATION — City or Town, State Baltimore, Md. | |
| 34. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark A. Chojnacki</i> | | | | 35. NAME AND ADDRESS OF FACILITY W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Balto., Md. 21224 | | | |
| 36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Critical Aortic Stenosis DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| 37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pernicious Anemia Mild Dementia | | | | | | | |
| 38. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 39. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 40. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 41. DATE OF INJURY (Month, Day, Year) | | 42. TIME OF INJURY M | | 43. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 44. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 45. DESCRIBE HOW INJURY OCCURRED | | | |
| 46. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 47. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 48. SIGNATURE AND TITLE OF CERTIFIER <i>Joyce Zeno</i> | | | | 49. LICENSE NUMBER ME 40925 | | 50. DATE SIGNED (Month, Day, Year) 1/7/94 | |
| 51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joyce A. Zeno 5601 Loch Raven Blvd. Baltimore, Maryland 21239 | | | | | | | |
| 52. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 53. REGISTRAR'S SIGNATURE <i>Judi Benion-Ruback</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00442

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|-------------------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Geraldine Elizabeth Ferkler | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 11, 1994 | | 3. TIME OF DEATH 2:00 A.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-20-2058 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 68 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) June 8, 1925 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 1122 Nottingham Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | | | 9c. COUNTY OF DEATH Anne Arundel | | | | |
| RESIDENCE OF DECEDENT | | | | 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Glen Burnie | | | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1122 Nottingham Drive | | 10f. ZIP CODE 21061 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frederick Bergman | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Schaefer | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Thomas B. Ferkler, 3rd. | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122 Nottingham Drive, Glen Burnie, MD 21061 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Mem. Pk. 1-14-94 | | DATE | | 20c. LOCATION — City or Town, State Glen Burnie, Maryland | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy., SE, Glen Burnie, MD 21061 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Recurrent Lung Carcinoma</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Pleural Effusion 2° to #1.</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER JD40519 | | 29d. DATE SIGNED (Month, Day, Year) January 12, 1994 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mirza Nusairee, M.D., 795 Aquahart Rd., Suite 131, Glen Burnie, MD 21061 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

94-0059-031

DWG

ITEMS: 23 PART I, 27, PER MEO FILM G-707 1/12/94 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00443

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROY LEON FULTZ | | | | 2. DATE OF DEATH MONTH 01 DAY 02 YEAR 94 | | 3. TIME OF DEATH 8:10 P M | |
| 4. SOCIAL SECURITY NUMBER 232-60-7457 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 54 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-10-1939 | |
| 9a. FACILITY NAME (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRINGS | | 9c. COUNTY OF DEATH MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY MONTGOMERY | | 10c. CITY, TOWN OR LOCATION SILVER SPRINGS | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1316 HORNELL DRIVE | | | | 10f. ZIP CODE 20905 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TECHNICIAN | | 16b. KIND OF BUSINESS/INDUSTRY NATIONAL SECURITY AGENCY | | | |
| 17. FATHER'S NAME (First, Middle, Last) ROY G. FULTZ | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARICE HUTCHINSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) PATRICIA FULTZ | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1316 HORNELL DRIVE, SILVER SPRINGS, MD 20905 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FAIRVIEW CEMETERY | | DATE 1-6-94 | | 20c. LOCATION — City or Town, State GORE, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY STALLINGS FUNERAL HOME, P.A. 3111 MOUNTAIN ROAD, PASADENA, MD 21122 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/04/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00444

| | | | | | | | | | | |
|---|--|--|--|---|--------------------------|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Theodore Carl Florenz, Sr. | | | | 2. DATE OF DEATH MONTH DAY YEAR January 8, 1994 | | 3. TIME OF DEATH 2:25 A. M | | | | |
| 4. SOCIAL SECURITY NUMBER 213-14-4632 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec. 21, 1919 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | |
| 9a. FACILITY NAME (If not institution, give street and number) Manor Care Ruxton | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Ruxton | | | 9c. COUNTY OF DEATH Baltimore | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Timonium | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 201 Locknell Road | | | | 10f. ZIP CODE 21093 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (13 or 5+) 2 | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manufactory Representative | | | 16b. KIND OF BUSINESS/INDUSTRY Furniture Company's | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frederick W. Florenz, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Gundelach | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs Pamela C. Florenz | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As #10 | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 1/10/94 | | DATE 1/10/94 | | 20c. LOCATION — City or Town, State Towson, Maryland | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald E. Schaefer</i> | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Carcinoma of colon</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Carcinoma of lung</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | Approximate interval Between Onset and Death 4 yrs 2 yrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>George T. Gilmore M.D.</i> | | | | | | 29c. LICENSE NUMBER D02325 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George T. Gilmore, M.D. 1717 York Road, Lutherville, Maryland 21093 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | 32. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00445 | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) BEATRICE GRAY | | | | 2. DATE OF DEATH JANUARY 5 1994 | | | | 3. TIME OF DEATH 10 : 03 P M | | | |
| 4. SOCIAL SECURITY NUMBER 183-20-6594 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 3-10-1918 | | 8. BIRTHPLACE (State or Foreign Country) NORTH CAROLINA | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 3600 W. FRANKLIN STREET | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? USA. | | | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY MD. GLASS COMPANY | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) CLEOPHAS GRAY | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SALLIE | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) ARTINAIS LORETTA BEARD | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2418 EDMONDSON AVENUE, BALTIMORE, MD. 21223 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK | | 20c. LOCATION — City or Town, State ARBUTUS, MARYLAND | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ischemic small and large bowel</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>vascular disease</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death 1 day years | | | | | | | | | | | |
| 24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Paul Brown M.D. | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/5/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Hospital, Baltimore, MD 21205 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00446

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDNA GRUPENHOFF | | | | 2. DATE OF DEATH MONTH Jan DAY 9 YEAR 1994 | | 3. TIME OF DEATH 4:15 pm | |
| 4. SOCIAL SECURITY NUMBER 269-07-0239 D | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 86 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 10, 1907 | |
| 9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7114 Bristol Rd. | | | | 10f. ZIP CODE 21212 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Edward Sullivan | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Pfallgraff | | | |
| 19a. INFORMANT'S NAME (Type/Print) David Grupenhoff | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11101 Old Carriage Rd. Glen Arm, Md. 21057 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns. 1/12/94 Timonium, Md. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert M. Kratz | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → UROSEPSIS DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DEHYDRATION DUE TO (OR AS A CONSEQUENCE OF): c. ALZHEIMER'S DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. CEREBRAL VASCULAR ACCIDENT | | | | | | Approximate Interval Between Onset and Death DAYS 1-2 DAYS YEARS 1991-1994 | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PARTIAL COLECTOMY PACEMAKER FOR SICK SINUS SYNDROME | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Ceballos, MD | | | | 29c. LICENSE NUMBER D 25886 | | 29d. DATE SIGNED (Month, Day, Year) 1.9.94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. CEBALLOS, M.D., ST. JOSEPH HOSPITAL, TOWSON, MARYLAND 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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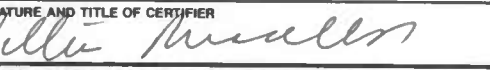
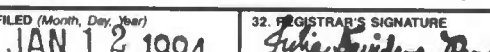
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Glebas Joseph | | | | 2. DATE OF DEATH MONTH 7 DAY 8 YEAR 94 | | | | 3. TIME OF DEATH 4:30 M | | | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 213-10-9582 | | | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JULY 4, 1909 | | 8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD | | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) ST. ELIZABETH NURSING HOME | | | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | | | | | |
| 10a. STATE MARYLAND | | | | 10b. COUNTY BALTIMORE | | | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 1120 GLORIA AVENUE | | | | | | | | 10f. ZIP CODE 21227 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 7TH GRADE | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TAILOR | | | | 16b. KIND OF BUSINESS/INDUSTRY CLOTHING MANUFACTURING | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN GLEBAS | | | | | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) MONICA BUCHNESS | | | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) FRANCES A. GLEBAS | | | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 GLORIA AVENUE-BALTIMORE, MD. 21227 | | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK MAUSOLEUM 1/12 | | | | 20c. LOCATION — City or Town, State BALTIMORE | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229 | | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { Progressive Supranuclear Palsy DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | Approximate Interval Between Onset and Death 12h Years | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  | | | | | | | | 29c. LICENSE NUMBER D30132 | | | | 29d. DATE SIGNED (Month, Day, Year) 1-10-94 | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM M RUSSELL MD 3320 BENSON AVE BALD MD 21227 | | | | | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | | | | | | | | | | | | | |

2000



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00448

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|---|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) DOROTHY A. GRAY | | | | 2. DATE OF DEATH MONTH JANUARY DAY 8 YEAR 1994 | | 3. TIME OF DEATH 1230 P.M. | | | | | |
| 4. SOCIAL SECURITY NUMBER 218-42-3574 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) October 23, 1910 | | 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 2307 Harlem Avenue | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher | | 16b. KIND OF BUSINESS/INDUSTRY Dist. of Columbia Schools | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Turner Anderson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Susan Weaver | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy Simpson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4222 Ridgewood Avenue Baltimore, MD 21215 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park | | DATE 1/13 | | 20c. LOCATION — City or Town, State Baltimore County, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Theron R. Bailey | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Due to (or as a consequence of): PNEUMONIA with Respiratory Failure Due to (or as a consequence of): Renal Failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Hypertension Urinary Tract Infection | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER C. Valmadril MD | | | | | | 29c. LICENSE NUMBER SINAI HOSPITAL | | 29d. DATE SIGNED (Month, Day, Year) January 8, 1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. VALMADRIL, MD; SINAI HOSPITAL OF BALTIMORE, BALTO, MD 21215 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 13 1994 | | | | 32. REGISTRAR'S SIGNATURE John D. ... | | | | | | | |

34400 70

James E. Galt

James E. Galt

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-18 Rev 1/89

2000-00

1000-00

1000-00



1000-00

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00450

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH W. Griffith GRIFFITH | | | | 2. DATE OF DEATH MONTH 01 DAY 08 YEAR 94 | | 3. TIME OF DEATH 11:50 A.M. | |
| 4. SOCIAL SECURITY NUMBER 213-05-5433 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-22-1915 | |
| 9a. FACILITY NAME (If not institution, give street and number) FRANCIS SCOTT KEY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH Maryland | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Dundalk | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7604 Poplar Road | | | | 10f. ZIP CODE 21222 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Army WW II | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Packer | | 16b. KIND OF BUSINESS/INDUSTRY Esskay Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph A. Griffith | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Magdalena Knorr | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Mary C. Griffith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7604 Poplar Road Dundalk, Maryland 21222 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 1/11/94 | | 20c. LOCATION — City or Town, State Towson, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Johnny L. Gibbs | | | | 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO INQUIRY | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute M.D. | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 1-8-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE John J. Henshaw | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE MEDICAL EXAMINER: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12-000-01

CHINESE

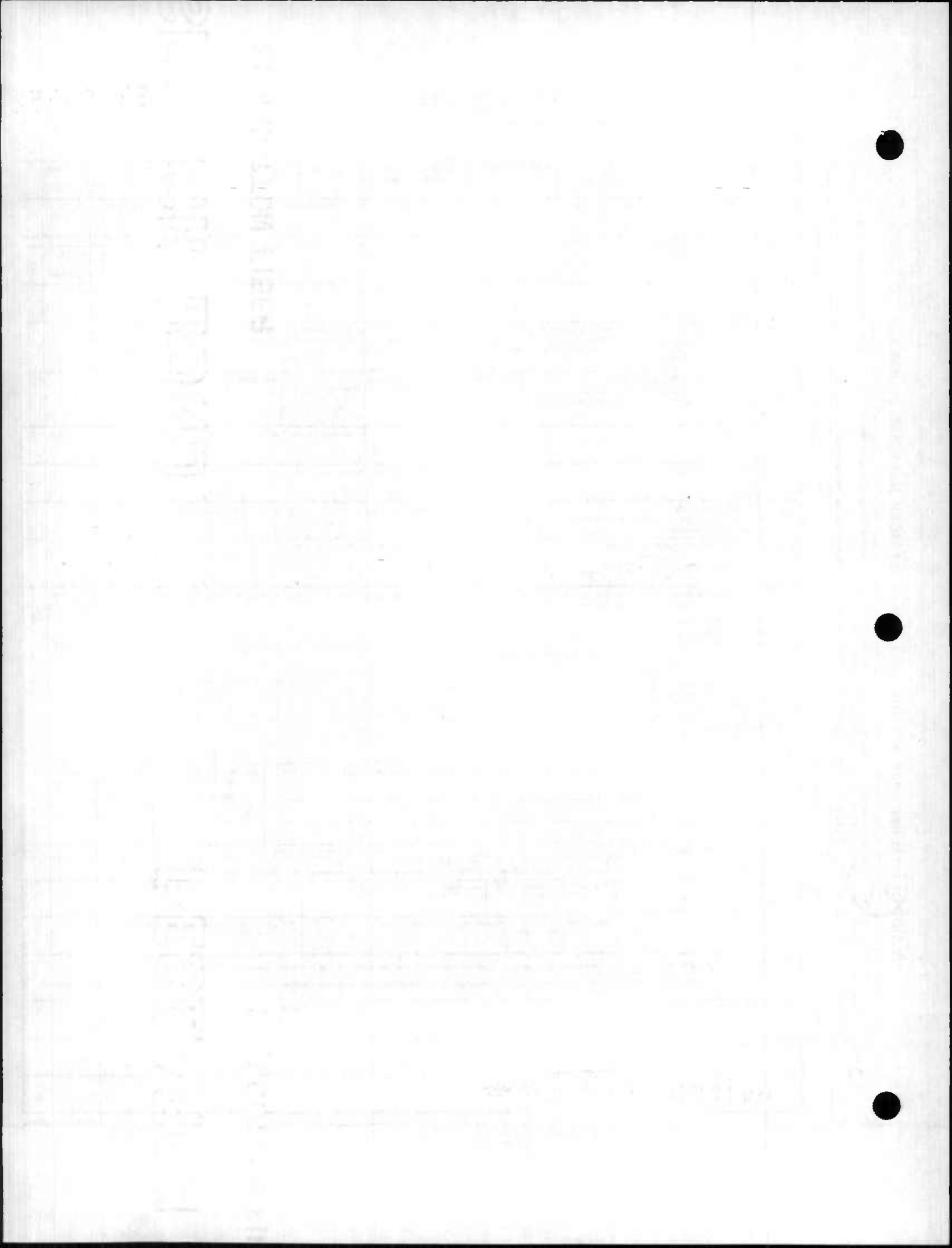
George W. G. G. G.

THE UNIVERSITY OF CHINA PRESS

1952

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00452 | | | | | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Augustina Margaret Goetz</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>5</i> YEAR <i>1994</i> | | 3. TIME OF DEATH M | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>219-05-4044</i> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>76</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>5-28-1917</i> | | | | | |
| 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | | | | 9a. FACILITY NAME (If not institution, give street and number) <i>7824 Gough Street</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Dundalk</i> | | | | | |
| 9c. COUNTY OF DEATH <i>Baltimore</i> | | | | 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Baltimore</i> | | | | | |
| 10c. CITY, TOWN OR LOCATION <i>Dundalk</i> | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>7824 Gough Street</i> | | | | | |
| 10f. ZIP CODE <i>21224</i> | | | | 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9th Grade</i> College (1-4 or 5+) <i>Homemaker</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Joseph Pistorio</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sadie</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Shirley A. Kulisiewicz</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12 Lakeside Drive New Freedom, PA 17349</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oak Lawn Cemetery 1/10/1994</i> | | 20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i> | | | | | |
| 21. SIGNATURE OF FUNERAL LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Metastatic Ovarian Cell Ca</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death <i>10 mo</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER <i>D33551</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/7/94</i> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael Huebner 9000 Frontin Sq Dr 21237</i> | | | | | | | | 31. DATE FILED (Month, Day, Year) <i>JAN 12 1994</i> | | | |



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00453

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHN RONALD HOLZINGER | | | | 2. DATE OF DEATH 01 MONTH 05 DAY 94 YEAR | | 3. TIME OF DEATH 5:00 P.M. | |
| 4. SOCIAL SECURITY NUMBER 219-40-7209 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 51 YRS. | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 12, 1942 | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | |
| 9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 402 S. GILMOR STREET | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Single 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES PEACETIME | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE College (1-4 or 5+) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) COMMUNICATIONS | | 16b. KIND OF BUSINESS/INDUSTRY SUNPAPERS | | | |
| 17. FATHER'S NAME (First, Middle, Last) PETER J. HOLZINGER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LULA MAY SWANN | | | |
| 19a. INFORMANT'S NAME (Type/Print) LULA MAY HOLZINGER | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 S. GILMOR STREET - BALTIMORE, MD. 21223 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK 1/10 | | 20c. LOCATION — City or Town, State ELKRIDGE, MD. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD. 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. PULMONARY THROMBOEMBOLISM | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): DEEP LEG VEIN THROMBOSIS | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 12-30-1993 | | 28b. TIME OF INJURY UNK M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED SLIP AND FELL ON ICE | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ON STREET | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) CENTER STREET | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 1-7-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOLW, JR. MD. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-707 1/27/94 t.t

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00454

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOHNNIE LEE HUDSON | | | | 2. DATE OF DEATH MONTH 01 DAY 06 YEAR 1994 | | 3. TIME OF DEATH 8:00 PM | |
| 4. SOCIAL SECURITY NUMBER 214-64-5872 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 36 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 8-16-1958 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 9c. COUNTY OF DEATH BALTIMORE | | | | 10a. STATE MD. | | 10b. COUNTY BALTIMORE CITY | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 221 SOUTH HILTON STREET | |
| 10f. ZIP CODE 21229 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA. | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTODIAL | | 16b. KIND OF BUSINESS/INDUSTRY BALTIMORE CITY | |
| 17. FATHER'S NAME (First, Middle, Last) YOU MAN FULLARD | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNIE HUDSON | | | |
| 19a. INFORMANT'S NAME (Type/Print) ANNIE SULLIVAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 SOUTH HILTON STREET, BALTIMORE, MARYLAND 21229 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY | | 20c. LOCATION — City or Town, State CATONSVILLE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. NARCOTIC, COCAINE AND ALCOHOL INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) UNKNOWN | | 28b. TIME OF INJURY UNKNOWN | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) UNKNOWN | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) UNKNOWN | | | | 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/07/1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GONZALEZ, 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BKK

ITEMS: 23 PART I, 27, 28a,b,c,d,e,f PER MEO G-707 1/28/94 reb

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00455

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CHARLES E. HACKETT JR. | | | | 2. DATE OF DEATH MONTH 01 DAY 08 YEAR 1994 | | 3. TIME OF DEATH 1935 M | |
| 4. SOCIAL SECURITY NUMBER 213- 70 - 0191 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 36 YRS. | | 7. DATE OF BIRTH MONTH 09 DAY 17 YEAR 57 | |
| 9a. FACILITY NAME (If not institution, give street and number) REAR OF 2330 DIVISION ST. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH CITY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 136 S. CULVER STREET | | | | 10f. ZIP CODE 21229 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY n/a | |
| 17. FATHER'S NAME (First, Middle, Last) CHARLES EMIL HACKETT SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) JUNE MALVICE HACKETT | | | |
| 19a. INFORMANT'S NAME (Type/Print) MICHAEL MANN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 136 S. CULVER STREET, BALTIMORE, MARYLAND 21229 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or crematory or other place) LLOYD RIDGE CEMETERY | | DATE 01-14 | | 20c. LOCATION — City or Town, State PIKESVILLE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See V. Holland</i> | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.- 1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE NARCOTIC AND COCAINE INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 1/8/94 | | 28b. TIME OF INJURY found: 7:25 M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: VACANT DWELLING REAR | | | | 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) BALTIMORE, MD. | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas J. Chudeas</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01-09-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julius Anderson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-173-510
ASP

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00456

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JONAS HARR | | 2. DATE OF DEATH MONTH 01 DAY 10 YEAR 1994 | | 3. TIME OF DEATH 5:45 A M | |
| 4. SOCIAL SECURITY NUMBER 284-18-5596 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 72 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 12 28 1921 | | 8. BIRTHPLACE (State or Foreign Country) Kentucky | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 327 S. WOODYEAR ST. | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore City | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 327 S. Woodyear Street | | 10f. ZIP CODE 21223 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) shipyard worker | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bethlehem Steel | | 17. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Arenda (UNKNOWN) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Katherine Harr | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 S. Woodyear St, Baltimore, MD 21223 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 1/13 | | 20c. LOCATION — City or Town, State Elkridge, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 Wilkens Avenue, Baltimore, MD 21229 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wound of Head DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) 01-10-1994 | | 28b. TIME OF INJURY 5:43 A M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED WOUND SELF-IN-FLICTED GUN SHOT | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 327 S. WOODYEAR ST. / BALTO | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King M.D. | | 29c. LICENSE NUMBER O.C.M.E | |
| 29d. DATE SIGNED (Month, Day, Year) 01-10-1994 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 00457

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RUTH HALL | | | | 2. DATE OF DEATH MONTH JANUARY DAY 07 , YEAR 1994 | | 3. TIME OF DEATH 7:40 p.m. | | | |
| 4. SOCIAL SECURITY NUMBER 212-36-1481 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Oct 13 1900 | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Maryland | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 2021 Lydonlea Way Apt C | | | | 10f. ZIP CODE 21239 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (14 or 5+) Domestic | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Harry Hall | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mamie Brooks | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Lorraine Stevenson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1823 Lydonlea Way Baltimore, MD 21239 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 1/12 | | 20c. LOCATION — City or Town, State Baltimore County, MD | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry L. Rollen</i> | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. ASPIRATION PNEUMONIA b. CEREBRO-VASCULAR ACCIDENT c. d. Approximate Interval Between Onset and Death EIGHT DAYS NINE DAYS TWELVE DAYS | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify) | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Shalini M.D.</i> | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) JANUARY, 07, 1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHALINI MAHAJAN, M.D., GOOD SAMARITAN HOSPITAL, BALTIMORE, MD. | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE <i>John S. ...</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00458

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROBERT HYMAN | | | | 2. DATE OF DEATH MONTH 01 DAY 08 YEAR 94 | | 3. TIME OF DEATH 2:54 A | |
| 4. SOCIAL SECURITY NUMBER 221-28-4939 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 50 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 02-24-43 | |
| 9a. FACILITY NAME (If not institution, give street and number) 256 HERRING COURT | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH NONE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY NONE | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10a. STREET AND NUMBER 256 HERRING COURT | | | | 10f. ZIP CODE 21231 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: AFRICAN AMERICAN | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9TH College (1-4 or 5+) NONE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY UNEMPLOYED | | | |
| 17. FATHER'S NAME (First, Middle, Last) HOWARD HYMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUISE MAYO | | | |
| 19a. INFORMANT'S NAME (Type/Print) CURTIS HYMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1326 N. BROADWAY BALTIMORE, MARYLAND 21213 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEM. 1-13-94 | | 20c. LOCATION — City or Town, State BALTO, MARYLAND | | 20d. DATE 1-13-94 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs, Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | ATHEROSCLEROTIC CARDIOVASCULAR DISEASE a. <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcoholism Fatty Liver Asthma | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. DESCRIBE NOW INJURY OCCURRED | | | |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/08/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS J. CHUTE MD. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00459

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ERNEST S. HILL | | 2. DATE OF DEATH MONTH JANUARY DAY 6 YEAR 1994 | | 3. TIME OF DEATH 1:50 P.M. | |
| 4. SOCIAL SECURITY NUMBER 212-46-0275 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 46 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 5-7-47 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | |
| 10a. STATE MD. | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER 611 S. CHARLES ST. | | 10f. ZIP CODE 21230 | |
| 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 11TH College (1-4 or 5+) BUS DRIVER | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BUS DRIVER | | 17. FATHER'S NAME (First, Middle, Last) HOWARD HILL | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) THELMA CARTER | |
| 19a. INFORMANT'S NAME (Type/Print) BARBARA STANTON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1333 TRAVELERS RD. BALTIMORE MD 21234 | | 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4. Donation 5. Other (Specify) | |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MAJOR CREMATORY 1400 CATONVILLE AVE | | 20c. LOCATION — City or Town, State MD | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE John P. March | |
| 22. NAME AND ADDRESS OF FACILITY LOWE'S FURNITURE HOME 210 FREDERICK ST. BALTIMORE MD 21229 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): b. ANOXIC ENCEPHALOPATHY DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | Approximate interval between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Brian C. Wallace MD | | 29c. LICENSE NUMBER D31136 | |
| 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN C. WALLACE, MD, 611 S. CHARLES ST., BALTIMORE MD 21230 | | 31. DATE FILED (Month, Day, Year) JAN 12 1994 | |
| 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00460

| | | | | | | | | | | | |
|---|--|---|--|---|-----------------|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM TURNER INGRAM | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 8, 1994 | | 3. TIME OF DEATH 3:00a M | | | | | |
| 4. SOCIAL SECURITY NUMBER 228-01-6294 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 79 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Feb. 2, 1914 | | 8. BIRTHPLACE (State or Foreign Country) Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis | | | 9c. COUNTY OF DEATH Anne Arundel | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Riva | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | |
| 10e. STREET AND NUMBER 2811 Whitehouse Road | | | | 10f. ZIP CODE 21140 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 8+) | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor | | | 15b. KIND OF BUSINESS/INDUSTRY Virginia St. Parole/Prob. | | | | |
| 17. FATHER'S NAME (First, Middle, Last) A. F. Ingram | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Hurt | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Barbara I. Most | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2811 Whitehouse Rd. Riva, MD 21140 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Highland Burial Park 1/11/94 | | | DATE 1/11/94 | | 20c. LOCATION — City or Town, State Virginia | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James Hardesty</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | | Approximate interval between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert B.</i> | | | | | | 29c. LICENSE NUMBER D33069 | | 29d. DATE SIGNED (Month, Day, Year) 1/18/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 Ridgely Ave. Suite 121 Annapolis MD 21401 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John A. ...</i> | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00461

| | | | | | | | |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ROSA JOHNSON | | | | 2. DATE OF DEATH MONTH 1 DAY 9 YEAR 94 | | 3. TIME OF DEATH 8:00 p M | |
| 4. SOCIAL SECURITY NUMBER 215-24-1808-A | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 111 YRS. | 7. DATE OF BIRTH (Month, Day, Year) 1-01-1883 | | 8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA | |
| 9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD. | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2815 WALBROOK AVENUE | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) MANNY SKEETER | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) LIANITA JEFFERSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2569 W. FAIRMOUNT AVENUE, BALTIMORE, MD. 21223 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY | | 20c. LOCATION — City or Town, State CATONSVILLE, MD. | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph H. Brown Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO OR AS A CONSEQUENCE OF: Pneumonia b. DUE TO OR AS A CONSEQUENCE OF: Digitalis Toxicity c. DUE TO OR AS A CONSEQUENCE OF: d. DUE TO OR AS A CONSEQUENCE OF: | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Terance L. Lamb</i> | | | | 29c. LICENSE NUMBER 037203 | | 29d. DATE SIGNED (Month, Day, Year) 1-9-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Terance LAMB no Liberty Medical Center, Baltimore md | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John J. ...</i> | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | REG. NO. 94 00462 | |
|--|--|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>ALBERT'S B. Johnson</i> | | | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>01 09 94</i> | | 3. TIME OF DEATH <i>1012 AM</i> | |
| 4. SOCIAL SECURITY NUMBER <i>250 10 5939</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>88</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>10 31 09</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>South Carolina</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Harbor City Hospital Center</i> | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH | |
| 10a. STATE <i>Maryland</i> | | | | | | 10b. COUNTY <i>Baltimore</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 10e. STREET AND NUMBER <i>2732 Bookert Drive</i> | | 10f. ZIP CODE <i>21225</i> | |
| 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th Grade</i> College (1-4 or 5+) <i>Brakeman</i> | | | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Brakeman</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Baltimore & Ohio Railroad</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Lucius Johnson</i> | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ella Burris</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Isabelle P. Johnson</i> | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2732 Bookert Drive Baltimore, Maryland 21225</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MD National Memorial Park 1/15</i> | | 20c. LOCATION — City or Town, State <i>Laurel, Maryland</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Emory R. Terry, Jr.</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY <i>Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sudden Death</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Sudden Death</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Cardiac Arrhythmia</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Hypertensive Cardiac Disease</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Hypertension</i> | | | | | | Approximate interval Between Onset and Death <i>25 min</i> <i>35 min</i> <i>>30 yrs</i> <i>>30 yrs.</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>70yr Smoker</i> <i>Polymyalgia Rheumatica.</i> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario Nicotolenko</i> | |
| 29c. LICENSE NUMBER <i>D41747</i> | | | | | | 29d. DATE SIGNED (Month, Day, Year) <i>01 09 94</i> | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mario Nicotolenko Harbor Hospital 3001 South Hanover ST Baltimore MD 21230</i> | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 12 1994</i> | | | | | | 32. REGISTRAR'S SIGNATURE <i>Jefferson</i> | | | |

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James D.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00463

| | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ELLEN O. JACKSON | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN 09 1994 | | | | 3. TIME OF DEATH 0419 | | | | | | | |
| 4. SOCIAL SECURITY NUMBER 216 105766 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 11-27-10 | | 8. BIRTHPLACE (State or Foreign Country) Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER 2217 West Lexington Street | | | | | | 10f. ZIP CODE 21223 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) Sorter | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sorter | | | | 16b. KIND OF BUSINESS/INDUSTRY Elite Laundry | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) James B. Jackson | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Carrington | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Olivia Weems | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2217 West Lexington St. Balto, MD 21223 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 1/13 | | | | 20c. LOCATION — City or Town, State Baltimore County MD | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, MD 21216 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Hypertension Renal Failure | | | | | | | | | | | | Approximate Interval Between Onset and Death Min Years | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Renal Failure | | | | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER D38675 | | 29d. DATE SIGNED (Month, Day, Year) 1/11/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOEL VESHUAM 1147 S HANOVER ST BALT 21230 | | | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | REGISTRAR'S SIGNATURE | | | | | | | | | | | |

FILED IN 100-100000

Wm. G. Brown

(A)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | CERTIFICATE OF DEATH | | REG. NO. | | 94 00464 | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ESTHER JONES | | | | | | 2. DATE OF DEATH MONTH January DAY 9 , YEAR 1994 | | 3. TIME OF DEATH 4:25 P M | | | |
| 4. SOCIAL SECURITY NUMBER 220 14 3799 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 4/2/15 | | 8. BIRTHPLACE (State or Foreign Country) MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Balto | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 1629 D. Broadway | | | | 10f. ZIP CODE 21213 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. A | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian | | | | 16b. KIND OF BUSINESS/INDUSTRY Balto. Public Schools | | | |
| 17. FATHER'S NAME (First, Middle, Last) George Jones | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sda Cornell | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rufus JONES | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1629 D. Broadway Balto. MD 21213 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. Calvary | | DATE 1/9/94 | | 20c. LOCATION — City or Town, State D. Co. County MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph B. Locks Jr | | | | | | 22. NAME AND ADDRESS OF FACILITY Locks Funeral Home 1304 D. Central | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | Approximate interval Between Onset and Death | |
| a. PULMONARY EMBOLISM | | | | | | | | | | 2 DAYS | |
| b. METASTATIC CANCER | | | | | | | | | | 2 YEARS | |
| c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | | | | 10 YEARS | |
| d. | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | |
| | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER W.C. Hance MA, MD | | | | | | 29c. LICENSE NUMBER M1045 | | 29d. DATE SIGNED (Month, Day, Year) 1/9/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM HUNTER MA MD 110 TOWER, JOHNS HOPKINS HOSPITAL, BALTIMORE, MD 21205 | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE John Anderson | | | | | | | |

2200 42

RECEIVED

2200 42

RECEIVED

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00465 | | | | | |
|---|--|--|--|---|--|---|--|---|--|----------------------------------|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH MONTH DAY YEAR | | | | 3. TIME OF DEATH M | | | | | |
| MARY KIRCHNER | | | | Jan. 9, 1994 | | | | | | | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | | 6. AGE (In yrs. last birthday) | | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) | | | | | |
| 216-44-9769 | | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 84 YRS. | | MAY 7, 1909 | | NEW JERSEY | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | 9c. COUNTY OF DEATH | | | | | |
| 802 BESTGATE ROAD | | | | ANNAPOLIS | | | | ANNE ARUNDEL | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | | | | | |
| MARYLAND | | ANNE ARUNDEL | | ANNAPOLIS | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | |
| 802 BESTGATE ROAD | | | | 21401 | | | | U.S.A. | | | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) | | 14. RACE — American Indian, Black, White, etc. | | | | | | | |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | Specify: WHITE | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| Elementary/Secondary (0-12) College (14 or 5+) | | | | SEAMSTRESS | | | | USNA | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | |
| JOHN PETER KIRCHNER | | | | KATHERINE POTH | | | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | |
| KATHERINE KIRCHNER | | | | 802 BESTGATE ROAD ANNAPOLIS, MD 21401 | | | | | | | | | |
| 20a. METHOD OF DISPOSITION | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | | | | | | | | |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | ST. MARY'S CEMETERY 1/12 | | ANNAPOLIS, MD | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| Bald J. J. J. | | | | HARDESTY FUNERAL HOME, PA 12 RIDGLEY AVENUE, ANNAPOLIS, MD 21401 | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | Approximate Interval Between Onset and Death | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | | | | | | | |
| a. Metastatic Cancer | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| | | | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | | | OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURED | | | |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | | | | | | | | | | | |
| | | | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) | | | | | | | | | | | | | |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) | | | | | |
| [Signature] | | | | 1736078 | | | | 1-11-94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | | |
| Steven D. Miller 900 Senteur Rd, Ste. 300, Annapolis, MD | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) | | | | | | | | | | | | | |
| JAN 12 1994 | | | | | | | | | | | | | |

52-6-3

94 00466

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>Dorothy P. Kline</u> <u>Dorothy Poole Kline</u> | | | | 2. DATE OF DEATH MONTH <u>07</u> DAY <u>08</u> YEAR <u>94</u> | | 3. TIME OF DEATH <u>4:15 p.m.</u> | |
| 4. SOCIAL SECURITY NUMBER <u>577-01-7742</u> | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <u>96</u> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <u>07-25-1897</u> | |
| 9a. FACILITY NAME (If not institution, give street and number) <u>Anne Arundel Medical Center</u> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <u>Annapolis, MD 21401</u> | | 9c. COUNTY OF DEATH <u>Anne Arundel</u> | |
| 10a. STATE <u>MD</u> D.C. | | | | 10b. COUNTY <u>Princ George</u> | | 10c. CITY, TOWN OR LOCATION <u>Washington</u> <u>Capitol Heights</u> | |
| 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER <u>4201 Massachusetts Ave. N.W.</u> <u>6100 Elder Street</u> | | | |
| 10f. ZIP CODE <u>20016</u> <u>20743-3104</u> | | | | 10g. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <u>White</u> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6</u> College (1-4 or 5+) <u></u> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u> | | 16b. KIND OF BUSINESS/INDUSTRY <u>Household</u> | |
| 17. FATHER'S NAME (First, Middle, Last) <u>Edwin Lewis Poole</u> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Eliza Rosina Hewitt</u> | | | |
| 19a. INFORMANT'S NAME <u>Joseph Marion Kline Jr.</u> <u>Joseph Kline Jr.</u> | | | | 19b. ADDRESS (Street and Number or Rural Route) <u>Capitol Heights, MD</u> <u>6100 Elder Street, Washington, DC 20743</u> | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Metro Crematory</u> | | 20c. LOCATION — City or Town, State <u>Baltimore, MD</u> | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Thomas A. Hardesty</u> | | | | 22. NAME AND ADDRESS OF FACILITY <u>Hardesty Funeral Home, P.A.</u> <u>12 Ridgely Ave., Annapolis, MD 21401</u> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory arrest</u> e. <u>Respiratory arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Congestive heart failure</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Aortic valve stenosis</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Fracture Right Hip</u> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <u>M</u> | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <u>S. E. Faust, MD</u> | | | | 29c. LICENSE NUMBER <u>D23595</u> | | 29d. DATE SIGNED (Month, Day, Year) <u>1-8-94</u> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Stephen E. Faust, MD 108 Forbes St., Annapolis, MD 21401</u> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <u>JAN 12 1994</u> | | | | 32. REGISTRAR'S SIGNATURE <u>Justine Anderson</u> | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


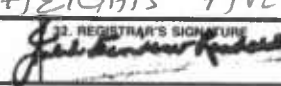
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00467

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Elsa M. Kuehnle | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 11, 1994 | | 3. TIME OF DEATH 1:00 A.M. M | |
| 4. SOCIAL SECURITY NUMBER 213-34-1879 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 89 YRS. | 7. DATE OF BIRTH (Month, Day, Year) July 7, 1904 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) Augsburg Lutheran Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Lochearn | | 9c. COUNTY OF DEATH Baltimore County | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore Co. | | 10c. CITY, TOWN OR LOCATION Lochearn | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 6811 Campfield Rd. | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 years | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) Franz Stassel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Reihl | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Bennett Linton | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4007 Villa Nova Rd. Baltimore, MD 21207 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation, Inc 1-11 | | 20c. LOCATION — City or Town, State Hampstead, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE CARDIOMYOPATHY. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Metastases for Breast CA H/o colon CA MULTI INFARCT DEMENTIA | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 26a. DATE OF INJURY (Month, Day, Year) | | 26b. TIME OF INJURY M | | 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| | | 26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26e. DESCRIBE HOW INJURY OCCURED | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Jasveen Lalwani | | | | | |
| | | 29c. LICENSE NUMBER D28195 | | 29d. DATE SIGNED (Month, Day, Year) 1/11/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7220 PARK HEIGHTS AVE BALD MD 2108 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE  | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

171-1000



171-1000

94 00468

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) MARIE S. KEMMET | | | | 2. DATE OF DEATH MONTH 1 DAY 8 YEAR 94 | | 3. TIME OF DEATH 1:00/P M | |
| 4. SOCIAL SECURITY NUMBER 212-05-1543 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 09-01-12 | |
| 9a. FACILITY NAME (If not institution, give street and number) Sykesville Eldercare Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Sykesville | | 9c. COUNTY OF DEATH Carroll | |
| 10a. STATE MD | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION Sykesville | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7309 Second Avenue | | | | 10f. ZIP CODE 21784 | | 10g. CITIZEN OF WHAT COUNTRY? U.S. | |
| 11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 17th grade | | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Receptionist | | 18b. KIND OF BUSINESS/INDUSTRY Apartment Complex | | | |
| 17. FATHER'S NAME (First, Middle, Last) John Scott | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lily Webster | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Carlton L. Kemmet | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6840 Autumn View Dr. Sykesville, MD 21784 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery | | 20c. LOCATION — City or Town, State 1/11/94 Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE James B. Covey | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of colon Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Tobacco Abuse | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Robert B. Kuoosuluz | | | | 29c. LICENSE NUMBER D17753 | | 29d. DATE SIGNED (Month, Day, Year) 1/8/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE John Andrew Rudek | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

33-11-13

2009-10-10 10:10 AM

ITEMS: 23 PART I, 27, PER MEO FILM G-707 1/27/94 t.t
FOR
1 - STATE REGISTRAR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

94 00469

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CARROLL LONESOME | | | | 2. DATE OF DEATH MONTH DAY YEAR 01 08 94 | | 3. TIME OF DEATH 6:45 P.M. | |
| 4. SOCIAL SECURITY NUMBER 215-28-3400 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 62 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9-28-31 | |
| 9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL RESIDENCE OF DECEDENT | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH MD | |
| 10a. STATE MD | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1940 Featherbed Ln. | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian | | 17. KIND OF BUSINESS/INDUSTRY State of MD | | | |
| 17. FATHER'S NAME (First, Middle, Last) (Joseph Lonesome) Percy Lonesome | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Lonesome | | | |
| 19a. INFORMANT'S NAME (Type/Print) Ida Lonesome | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1940 Featherbed Ln. Balto., MD 21207 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park 1/13 | | 20c. LOCATION — City or Town, State Balto., Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i> | | | | 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St. Balto., Md 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King M.D.</i> | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 1-9-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KING MD. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 00470

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) William Lomax | | | | 2. DATE OF DEATH MONTH 1 DAY 7 YEAR 94 | | 3. TIME OF DEATH 8:25 P.M. | |
| 4. SOCIAL SECURITY NUMBER 242-09-0671 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 82 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 11/15/00 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9a. FACILITY NAME (If not institution, give street and number) 2225 WHEATLEY DRIVE | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, MD | |
| 9c. COUNTY OF DEATH n/a | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY n/a | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2225 WHEATLEY DRIVE | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 7TH | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABLED Laborer | | 16b. KING OF BUSINESS/INDUSTRY n/a | | | |
| 17. FATHER'S NAME (First, Middle, Last) ELIJAH LOMAX | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) GLENDORA BARRETT | | | |
| 19a. INFORMANT'S NAME (Type/Print) THOMASINE JOHNSON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2225 WHEATLEY DRIVE, Apt. 101, BALTIMORE, MARYLAND 21207 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA CEMETERY 1-13 | | 20c. LOCATION — City or Town, State OWINGS MILLS, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>See V. Holland</i> | | | | 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH. - 1101 E. NORTH AVENUE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death 2 wks. | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. Decubitus Ulcers DUE TO (OR AS A CONSEQUENCE OF): | | | | 4 mos. | |
| | | c. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. _____ DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's disease, Peripheral Vascular Disease | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>D. Snow</i> | | | | 29c. LICENSE NUMBER D24149 | | 29d. DATE SIGNED (Month, Day, Year) Jan 10, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dorothy A. Snow, M.D. 10 N. Greene St. Balt MD 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 94 00471 |
|--|--|--|---|---|---|---|---|---|--|-------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) Richard C. Lewis | | | | | | 2. DATE OF DEATH MONTH Jan. DAY 9 YEAR 1994 | | 3. TIME OF DEATH 8:30 A-M | | |
| 4. SOCIAL SECURITY NUMBER 074-16-9326 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 78 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Jan. 12, 1915 | | 8. BIRTHPLACE (State or Foreign Country) New York | | |
| 9a. FACILITY NAME (If not institution, give street and number) 4110 Buckingham Road | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH Baltimore | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 4110 Buckingham Road | | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic Appliances | | | 16b. KIND OF BUSINESS/INDUSTRY Self-Employed | | | |
| 17. FATHER'S NAME (First, Middle, Last) Burton H. Lewis | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mae Helmer | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Blanche Lewis | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4110 Buckingham Road Baltimore MD 21207 | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olive U.M. Ch. Cemetery 1/12 | | | OATE | | 20c. LOCATION — City or Town, State Randallstown, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of caecum colon DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma of bladder since 1990 | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> | | | | | 29c. LICENSE NUMBER 20-2225 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W. B. Daniels, Jr. Union Memorial Hospice, Baltimore 21218 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00472 | |
|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) MIRIAM | | 2. DATE OF DEATH MONTH DAY YEAR 01 06 94 | | 3. TIME OF DEATH 1:55 PM | | | |
| 4. SOCIAL SECURITY NUMBER 219-30-6187 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) DEC 23, 1904 | |
| 8. BIRTHPLACE (State or Foreign Country) RUSSIA | | 9a. FACILITY NAME (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON | | 9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE | | 9c. COUNTY OF DEATH MONTGOMERY | |
| 10a. STATE MARYLAND | | 10b. COUNTY MONTGOMERY | | 10c. CITY, TOWN OR LOCATION ROCKVILLE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1801 E JEFFERSON ST | | 10f. ZIP CODE 20850 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MANAGER | | 16b. KIND OF BUSINESS/INDUSTRY PARKLANE HOSIERY CO. | | | |
| 17. FATHER'S NAME (First, Middle, Last) BENJAMIN GREENSPON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FANNY SILBERBERG | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MRS SYLVIA GOLLUB | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 PERSIMMON CT BETHESDA MD 20817 | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) TIEFERTH ISRAEL 1/9/94 | | 20c. LOCATION — City or Town, State ROSEDALE MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott M. Gittlin | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. SEPSIS URINARY b. DUE TO (OR AS A CONSEQUENCE OF): GENERALIZED ARTERIOSCLEROSIS c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 48 Hours YEARS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA, NORMAL PRESSURE HYDROCEPHALUS | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Steven Lipson MD | | 29c. LICENSE NUMBER MD D 5885 | | 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN LIPSON 6121 MONTROSE ROAD, ROCKVILLE, MD 20855 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE John T. ... | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00473 | |
|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) Jeannette Ltebowitz | | | | 2. DATE OF DEATH MONTH 1 DAY 10 YEAR 1994 | | 3. TIME OF DEATH 9:20 AM | |
| 4. SOCIAL SECURITY NUMBER 213-20-1111 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 69 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) JAN. 9, 1925 | |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | 9. COUNTY OF DEATH BALTIMORE | | | |
| 9a. FACILITY NAME (If not institution, give street and number) NORTHWEST HOSPITAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN | | 9c. COUNTY OF DEATH BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7202 ROCKLAND HILLS DRIVE, APT. 210 | | | | 10f. ZIP CODE 21209 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BOOKKEEPER | | 16b. KIND OF BUSINESS/INDUSTRY ACCOUNTING | |
| 17. FATHER'S NAME (First, Middle, Last) HYMAN SHINDEL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH HARRIS | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR MARK LIEBOWITZ | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 SILENTWOOD COURT OWINGS MILLS, MD 21117 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HEBREW YOUNG MENS - 1-10-94 BALTIMORE, MD | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Breast Carcinoma Approximate Interval Between Onset and Death a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D. | | | |
| 29c. LICENSE NUMBER D 37174 | | | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SONG CHOL CHON M.D. Northwest Hospital Center, Randallstown, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00474

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Alfred H. Lieberman | | | | 2. DATE OF DEATH MONTH January DAY 9 YEAR 1994 | | | | 3. TIME OF DEATH 0515 (A M) | |
| 4. SOCIAL SECURITY NUMBER 123-01-9775 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 73 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) OCT. 13, 1920 | | 8. BIRTHPLACE (State or Foreign Country) NEW YORK | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4800 YELLOWWOOD AVENUE APT. 219 | | | | 10f. ZIP CODE 21209 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WAITER | | | 16b. KIND OF BUSINESS/INDUSTRY RESTAURANT | | |
| 17. FATHER'S NAME (First, Middle, Last) RUBEN LIEBERMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) YETTA TOBIS | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. HAROLD LIEBERMAN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10966 STRATHMORE DR; LOS ANGELES, CA 90024 | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP SERVICE CORP. | | DATE 1-11-94 | | 20c. LOCATION — City or Town, State TOWSON, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Del D Lewis</i> | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer with metastases a. Lung Cancer with metastases DUE TO (OR AS A CONSEQUENCE OF): b. Colorectal Cancer with metastases DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death 2 months unknown | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Leprosy | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sam Seegal</i> Medical Intern | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) January 9, 1994 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sam Seegal, Do., Sinai Hospital | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmission certificate. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

AT 400 48

CLIQUE 10



ITEM: 4. PER F.H. FILM G-708 2/22/94 t.t.
ITEMS 28e, 28f, PER MEO FILM G-707 1/25/94 t.t

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00475

| | | | | | | | | | | | |
|---|--|--|---|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANGELINA M. LOMBARDI | | | | 2. DATE OF DEATH MONTH 1 / DAY 9 / YEAR 94 | | 3. TIME OF DEATH 9 15 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER 139-32-1504 023-65-3132 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 76 1/2 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 03 / 26 / 17 | | 8. BIRTHPLACE (State or Foreign Country) New Jersey | | | |
| 9a. FACILITY NAME (If not institution, give street and number) University Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | | 9c. COUNTY OF DEATH | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | |
| 10a. STATE New Jersey | | 10b. COUNTY Morris | | 10c. CITY, TOWN OR LOCATION Jefferson Township | | | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 229 Espanong Rd. | | | | 10f. ZIP CODE 07849 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 yrs College (1-4 or 5+) College (1-4 or 5+) | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | 16b. KIND OF BUSINESS/INDUSTRY Own Home | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Frank Sommo | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Bruno | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Theresa Hardy | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10477 Sternwheel Place Columbia, Md. 21044 | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Theresa Cemetery | | 20c. LOCATION — City or Town, State 1-15 Summit, New Jersey | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Subdural Hemorrhage</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Fall</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Anticoagulation for Aortic Valve Replacement</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) 1/9/94 | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED Fall/syncope | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) AT HOME | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COLUMBIA, MARYLAND 10477 STERNWHEEL PLACE | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER #6730 | | | 29d. DATE SIGNED (Month, Day, Year) 1/9/94 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Victor Caraballo University Hospital Baltimore, Md. | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

94 00476

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Rosabelle Armiger Marshall | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 10 1994 | | 3. TIME OF DEATH 8 P M | |
| 4. SOCIAL SECURITY NUMBER 216-12-0786 | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 81 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept 27 1912 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9. COUNTY OF DEATH Anne Arundel | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 3916 River Club Drive | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Edgewater | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Edgewater | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 3916 River Club Drive | | | |
| 10f. ZIP CODE 21037 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Food Manager | | 16b. KIND OF BUSINESS/INDUSTRY Retail Sales | | | |
| 17. FATHER'S NAME (First, Middle, Last) Thomas Henry Armiger | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dernie L. (unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print) Merle Roberts | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3916 River Club Dr. Edgewater MD 21037 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory | | 20c. LOCATION — City or Town, State Baltimore, MD | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas A Hardesty | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Colon Carcinoma | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Consecutive Heart Failure | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Wayne D Bierbaum, MD | | | | 29c. LICENSE NUMBER 030563 | | 29d. DATE SIGNED (Month, Day, Year) 11/11/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wayne D Bierbaum 134 Owensville Rd West River, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE John Benner Rudecki | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05/09/88

Handwritten signature 05/09/88

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00477

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Albert Lyons Moreland | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan. 11, 1994 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 220-09-6956 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 74 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Sept 18, 1919 | |
| 9a. FACILITY NAME (If not institution, give street and number) 441 W Bay Front Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Lothian | | 9c. COUNTY OF DEATH Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Lothian | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 441 W Bay Front Road | | | | 10f. ZIP CODE 20711 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer | | 15b. KIND OF BUSINESS/INDUSTRY Farming | |
| 17. FATHER'S NAME (First, Middle, Last) Clarence Russell Mareland Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ella Skinner | | | |
| 19a. INFORMANT'S NAME (Type/Print) Margaret Estelle Moreland | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 441 W Bay Front Road, Lothian, MD 20711 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion U.M. Cemetery | | 20c. LOCATION — City or Town, State Lothian, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Hardesty Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 12401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | | | | | | |
| a. <i>pulmonary edema</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. <i>degeneration</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>John D. Saperstein MD</i> | | | | 29c. LICENSE NUMBER 1D80768 | | 29d. DATE SIGNED (Month, Day, Year) 1-12-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John D. Saperstein MD 1837 FOREST DR, ANNAPOLIS MD 21401 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>John D. Saperstein</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00478

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM MARSH | | | | 2. DATE OF DEATH MONTH 01 DAY 03 YEAR 94 | | 3. TIME OF DEATH 2:32 P M | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 56 YRS. | 7a. IF UNDER 1 YEAR MONTHS _____ DAYS _____ | 7b. IF UNDER 24 HRS. HOURS _____ MIN. _____ | 7. DATE OF BIRTH (Month, Day, Year) | |
| 9a. FACILITY NAME (If not institution, give street and number) 4002 GRIER NURSERY ROAD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH PYLESVILLE | | 9c. COUNTY OF DEATH HARFORD | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Pylesville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4002 Grier Nursery Road | | | | 10f. ZIP CODE 21132 | | 10g. CITIZEN OF WHAT COUNTRY? | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state removal | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | 20d. DATE | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular Disease a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M _____ | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER Denise J. Chute MD | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 01/04/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00479

| | | | | | | | | | |
|--|--|--|--|---|--------------------------------|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) KATHERINE McCRAE | | | | 2. DATE OF DEATH MONTH 1 DAY 6 YEAR 94 | | 3. TIME OF DEATH 12:25 P M | | | |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 71 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 10-16-1923 | | | |
| 8. BIRTHPLACE (State or Foreign Country) GEORGIA | | | | 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE MD. | | 10b. COUNTY | | | |
| 10c. CITY, TOWN OR LOCATION BALTIMORE CITY | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER 818 HARLEM AVENUE | | | | 10f. ZIP CODE 21201 | | 10g. CITIZEN OF WHAT COUNTRY? USA. | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FACTORY WORKER | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) LINDSAY HARDWICK | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLA HARDWICK | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) BONITA WATTS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1614 McCULLOUGH STREET, BALTIMORE, MD. 21217 | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VOSHALL MEMORIAL GARDENS | | 20c. LOCATION — City or Town, State BALTIMORE, MARYLAND | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | Approximate interval Between Onset and Death Unknown EST 2-3 hrs | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| | | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1-6-94 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Janet O. Mahoney 28 So Green St | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE | | | | | | | |

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94-0120-510

B.K.S

Item 1, g-707, 1-12-94, dr

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00480

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) PAUL Daniel Michalisko | | | | 2. DATE OF DEATH MONTH 01 DAY 07 YEAR 94 | | 3. TIME OF DEATH 6:10 A M | |
| 4. SOCIAL SECURITY NUMBER 219-40-7532 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 52 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9 4 1941 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) FRANCES SCOTT KEY MEDICAL CT. | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | |
| 9c. COUNTY OF DEATH | | | | 10a. STATE Pa. | | | |
| 10b. COUNTY | | | | 10c. CITY, TOWN OR LOCATION New Freedom | | | |
| 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER Stone Ridge Dr. 6 | | | |
| 10f. ZIP CODE 17349 | | | | 10g. CITIZEN OF WHAT COUNTRY? United States | | | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreman | | 16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Michalisko | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Manica | | | |
| 19a. INFORMANT'S NAME (Type/Print) Katherine Michalisko | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stone Ridge Dr. 6 New Freedom Pa. 17349 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn 1/11 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark A. Chojnacki</i> | | | | 22. NAME AND ADDRESS OF FACILITY W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Balto., Md. 21224 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute MD</i> | | | | 29c. LICENSE NUMBER O.C.M.E | | 29d. DATE SIGNED (Month, Day, Year) 1-8-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE <i>John Benison-Ruback</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00481

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) LUTHER M MCDONOUGH JR. | | | | 2. DATE OF DEATH MONTH JANUARY DAY 10 YEAR 1994 | | 3. TIME OF DEATH 01:30 PM | |
| 4. SOCIAL SECURITY NUMBER 215-32-4610 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 59 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) May 2, 1934 | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH Baltimore City | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Carroll | | 10c. CITY, TOWN OR LOCATION Mt. Airy | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 408 Prospect Road | | | | 10f. ZIP CODE 21771 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 61 - 62 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter | | 16b. KIND OF BUSINESS/INDUSTRY M.A. Bongiovanni | |
| 17. FATHER'S NAME (First, Middle, Last) Luther Marshall McDonough, Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Daisy Ethel Linthicum | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. Kenneth McDonough | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Baker Street Mt. Airy, MD 21771 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pine Grove Cemetery | | DATE 1/14 | | 20c. LOCATION — City or Town, State Mt Airy, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen M Jenkins</i> | | | | 22. NAME AND ADDRESS OF FACILITY Burrier-Queen Funeral Directors, P.A. 21784 1212 West Old Liberty Road Winfield, MD | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary fibrosis DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | Approximate Interval Between Onset and Death 18 months |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Weiner</i> MEDICAL INTERN | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael Weiner, Johns Hopkins Hosp., Tower 110, 600 N. Wolfe St, Baltimore MD 21287 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

1081

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE MEDICAL EXAMINER: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00482

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) Eddie L. Mellerson | | | | 2. DATE OF DEATH MONTH 01 DAY 04 YEAR 94 | | 3. TIME OF DEATH 2140P M | |
| 4. SOCIAL SECURITY NUMBER 249-70-7971 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 51 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-16-42 | |
| 8. FACILITY NAME (If not institution, give street and number) Northwest Hospital Ctr | | | | 9. CITY, TOWN OR LOCATION OF DEATH Randallstown | | 10. COUNTY OF DEATH Baltimore | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 7009 North Alter Street | | | | 10f. ZIP CODE 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY Crown Cork & Seal Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last) Birdie Mellerson | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Queen Marion | | | |
| 19a. INFORMANT'S NAME (Type/Print) Rena L. Mellerson | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7009 N. Alter St. Baltimore, Maryland 21207 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery | | 20c. LOCATION — City or Town, State 11/8 Baltimore County, MD | | 20d. DATE 11/8 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, Maryland 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → - Acute coronary event. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST - Generalized coronary artery disease a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Heart Failure Cardiac arrhythmias Hypertension | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Nomicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD. |
| 29c. LICENSE NUMBER D-22609 | | 29d. DATE SIGNED (Month, Day, Year) 11/7/94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RUBEN REIDER M.D. -7445 KUMACE BRANCH Rd Glen Burnie | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> Md 21062 | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00483

| | | | | | | | |
|---|--|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) HERBERT H MONROE | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 3, 1994 | | 3. TIME OF DEATH M M | |
| 4. SOCIAL SECURITY NUMBER 239-58-1175 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 64 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Dec 25 1929 | |
| 8. BIRTHPLACE (State or Foreign Country) North Carolina | | | | 9. COUNTY OF DEATH Baltimore | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY Baltimore | | | |
| 10c. CITY, TOWN OR LOCATION Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 2321 Windsor Avenue | | | | 10f. ZIP CODE 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean War | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer | | 16b. KIND OF BUSINESS/INDUSTRY Balto City Water Works Dept | | | |
| 17. FATHER'S NAME (First, Middle, Last) Homer Monroe | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Maggie | | | |
| 19a. INFORMANT'S NAME (Type/Print) Florence Monroe | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2321 Windsor Avenue Baltimore, MD 21216 | | | |
| 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veteran Cemetery/Garrison 1/10 | | 20c. LOCATION — City or Town, State Owings Mills, MD | | 20d. DATE 1/10 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Herbert E. Nutter | | | | 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, MD 21216 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio-pulmonary arrest Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Metastatic carcinoma of lung Hypertension | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 27. DATE OF INJURY (Month, Day, Year) | | 28. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 29. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. Khan MD | | | | 29c. LICENSE NUMBER D 25391 | | 29d. DATE SIGNED (Month, Day, Year) 1-7-94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. KHAN 5601- Loch Raven Blvd, Baltimore MD 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE John Benson Rucker | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00484

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>James Morris</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>January 10 1994</i> | | 3. TIME OF DEATH <i>1:53 P M</i> | |
| 4. SOCIAL SECURITY NUMBER <i>218 64 0620</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>36</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>7/21/57</i> | |
| 8. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH <i>Md.</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>Md.</i> | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>6600 Vincent Lane</i> | | | | 10f. ZIP CODE <i>21215</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Meat Cutter</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Food</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>James Jackson</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Constance Lee Morris</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Yvonne Morris</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6600 Vincent La. Balto., Md. 21215</i> | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>King Memorial Park 1/15</i> | | 20c. LOCATION — City or Town, State <i>Balto., Md.</i> | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lactic acidosis + sepsis causing cardiac arrest</i> (Leading to) | | | | | | | |
| Approximate Interval Between Onset and Death <i>3 days</i> | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>AIDS</i> <i>Renal Failure</i> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 29f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mi Mi House Officer</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>1/10/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ALI NIAK - Sinai Hospital of Baltimore</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 12 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>John Davidson Anderson</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 24 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18490 40

RECEIVED

RECEIVED

St. John's, Nfld.

St. John's, Nfld.

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.

I am sorry to hear that you are unable to attend the meeting of the 15th inst. but I trust that you will be able to do so on the 22nd inst. as I have been informed that you will be in the city at that time.

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Signature]

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The medical examiner must be notified at once.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00485

| | | | | | |
|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SANDRA Mari MOSSHOLDER | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 6, 1994 | | 3. TIME OF DEATH 5:41P | |
| 4. SOCIAL SECURITY NUMBER 290-56-1936 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 24 YRS. | |
| 7. DATE OF BIRTH (Month, Day, Year) 10-7-1969 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | 9. COUNTY OF DEATH | |
| 9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Dundalk | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 2601 Gray Manor Terrace | | 10f. ZIP CODE 21222 | |
| 10g. CITIZEN OF WHAT COUNTRY? United States | | 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | 15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cashier | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade | | 16. KIND OF BUSINESS/INDUSTRY Channel | | 17. FATHER'S NAME (First, Middle, Last) James Mossholder | |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname) Betty Rouse | | 19a. INFORMANT'S NAME (Type/Print) Betty Jakubowski | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3470 Dunhaven Road Dundalk, Maryland 21222 | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Ht. of Jesus 1/10/94 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Herniation DUE TO (OR AS A CONSEQUENCE OF): Hemophilic B DUE TO (OR AS A CONSEQUENCE OF): Baculodermis DUE TO (OR AS A CONSEQUENCE OF): AIDS | | Approximate interval Between Onset and Death 2 min 24 yrs 5 yrs 5 yrs | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Disseminated MAI, Acidosis, Candida esophagitis, Pneumonia, Hypokalemia, Hyponatremia | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NUMBER L4799 | |
| 29d. DATE SIGNED (Month, Day, Year) 1/6/94 | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TAKE SUNG - JHH Baltimore, MD 21205 | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE | | | |

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94 00486

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EMMA MARSHALL | | | | 2. DATE OF DEATH MONTH JANUARY , DAY 08 , YEAR 1994 | | | | 3. TIME OF DEATH 12:50 A.M. | | |
| 4. SOCIAL SECURITY NUMBER 215 05 2424D | | 5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) 89 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year) 9-11-04 | | |
| 8. BIRTHPLACE (State or Foreign Country) MD. | | | | 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hosp. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO. MD | | |
| 9c. COUNTY OF DEATH MD | | | | 10a. STATE MD | | | | 10b. COUNTY BALTO. | | |
| 10c. CITY, TOWN OR LOCATION BALTO. | | | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER 1210 BONAPARTE AVE BALTO. MD | | |
| 10f. ZIP CODE 21218 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A | | | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | | | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last) MARYLAND HARRIS | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY E. GREEN | | | | 19a. INFORMANT'S NAME (Type/Print) NADINE T HARRIS | | |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 BONAPARTE AVE. BALTO. MD 21218 | | | | 20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. CALVARY | | |
| 20c. LOCATION — City or Town, State D.A. COUNTY. MD | | | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Lock | | | | 22. NAME AND ADDRESS OF FACILITY Lock Funeral Home 1304 N. Central St. | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST NASOGASTRIC TUBE FEEDING DEMENTIA | | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Shalini M.D. | | | | 29c. LICENSE NUMBER | | | | 29d. DATE SIGNED (Month, Day, Year) JANUARY, 08, 1994 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHALINI MAHAJAN, M.D. GOOD SAMARITAN HOSPITAL, BALTIMORE, MD | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00487

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) RICHARD L. MOHLHENRICH | | | | 2. DATE OF DEATH MONTH 01 DAY 10 YEAR 1994 | | 3. TIME OF DEATH 9:45 A M | |
| 4. SOCIAL SECURITY NUMBER 212-22-7604 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday) 67 YRS. | 7. DATE OF BIRTH (Month, Day, Year) Sept. 27, 1926 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number) G.B.M.C. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Lutherville | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 148 Westbury Road | | | | 10f. ZIP CODE 21093 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed | | 16b. KIND OF BUSINESS/INDUSTRY Hydraulic Business | | | |
| 17. FATHER'S NAME (First, Middle, Last) Randolph Mohlhenrich | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Lennert | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Carol D. Mohlhenrich | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10a - #10f | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem.Gdns. 1/13/94 | | 20c. LOCATION — City or Town, State Timonium, Balto. Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Maryland 21204 | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiopulmonary arrest DUE TO (OR AS A CONSEQUENCE OF): b. respiratory failure DUE TO (OR AS A CONSEQUENCE OF): c. hemiparesis DUE TO (OR AS A CONSEQUENCE OF): d. lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | Approximate interval Between Onset and Death 5 days |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. anoxic encephalopathy with coma | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER F. T. Souweire MD | | | | 29c. LICENSE NUMBER 024732 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/92 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) F. T. Souweire MD 1134 York Rd, Lutherville Md. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10:00 42

N. N.



at the end of the line

10:00 42



1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00488

| | | | | | |
|--|--|---|--|---|--------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Earle Sylvester Nash</i> | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>9</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>5:20 p.m.</i> |
| 4. SOCIAL SECURITY NUMBER <i>21503 0747</i> | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>74</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year) <i>05-18-19</i> | 8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Harbor Hospital Ctr.</i> | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | 9c. COUNTY OF DEATH |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE <i>Florida</i> | | 10b. COUNTY <i>Palatka</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | |
| 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER <i>Rt 4 Box 1738</i> | | 10f. ZIP CODE <i>32077</i> | |
| 10g. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>12 yrs.</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Superintendent</i> | | 16b. KIND OF BUSINESS/INDUSTRY <i>Steel Industry</i> | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Charles E. Nash</i> | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Sue Forrest Carnes</i> | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Walter G. Nash</i> | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>106 Tower Drive Stevensville, MD 21666</i> | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Glen Haven Mem. Park 1/13</i> | | 20c. LOCATION — City or Town, State <i>Glen Burnie, Maryland</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | 22. NAME AND ADDRESS OF FACILITY <i>Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061</i> | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Heart Failure</i> | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | |
| a. <i>Arteriosclerotic Cardiovascular Disease</i> 12 year | | | | | |
| b. <i>Hypertension</i> 15 years | | | | | |
| c. <i>Pneumonia</i> | | | | | |
| d. <i>COPD</i> | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| <i>Pneumonia</i> | | | | | |
| <i>COPD</i> | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Cabrera V.</i> | | 29c. LICENSE NUMBER <i>HOUSE OFFICER</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1-9-94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>CABRERA, MIGUEL F.</i> | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 12 1994</i> | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

18400 50

18400 50

2

18400 50

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

94 00489

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH H. NICHOLS JR. | | | | 2. DATE OF DEATH MONTH 1 DAY 8 YEAR 94 | | 3. TIME OF DEATH M | |
| 4. SOCIAL SECURITY NUMBER 218-16-7539 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 71 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 1-2-23 | |
| 9a. FACILITY NAME (If not institution, give street and number) 4428 MARRIOTTSTOWN RD | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTO | | 9c. COUNTY OF DEATH BALTO | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | | 10b. COUNTY BALTO | | 10c. CITY, TOWN OR LOCATION RANDALLSTOWN | | 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 4428 MARRIOTTSTOWN RD | | | | 10f. ZIP CODE 21117 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) College | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNKNOWN | | 16b. KIND OF BUSINESS/INDUSTRY HARDWARE SPECIALITY INC. | | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH H. NICHOLS SR. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) LENA A. MILLER | | | |
| 19a. INFORMANT'S NAME (Type/Print) MARY E. NICHOLS | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4428 MARRIOTTSTOWN RD BALTO, MD 21117 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VETERAN 11394 | | 20c. LOCATION — City or Town, State OWINGS MILLS, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Debra March</i> | | | | 22. NAME AND ADDRESS OF FACILITY MARCH F/H WEST 4300 WABASH AVE | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Metastatic pancreatic cancer</i> DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Chang</i> | | | | 29c. LICENSE NUMBER D16587 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5601 Loch Raven Blvd Suite 107, Baltimore, MD 21239 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodale</i> | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last) Howard WILLIAM Peters | | | | 2. DATE OF DEATH MONTH DAY YEAR Jan 10, 1994 | |
| 3. TIME OF DEATH 2:50 AM | | 4. SOCIAL SECURITY NUMBER 523-07-7621 | | 5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | |
| 6. AGE (In yrs. last birthday) 83 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Aug. 14, 1910 | | 8. BIRTHPLACE (State or Foreign Country) Colo | |
| 9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | | 9c. COUNTY OF DEATH Anne Arundel | |
| 10a. STATE Maryland | | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Edgewater | |
| 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 3718 Carroll Road | | 10f. ZIP CODE 21037 | |
| 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES WWII | |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) Automobile Mechanic | |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Automotive | | 17. FATHER'S NAME (First, Middle, Last) John William Peters | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Perkins | |
| 19a. INFORMANT'S NAME (Type/Print) Pamela Peters Ebersole | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3718 Carroll Road, Edgewater, MD 21037 | | | |
| 20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory | | 20c. LOCATION — City or Town, State Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kimberly S. Rowe</i> | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure - idiopathic DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kevin Doyle</i> | | 29c. LICENSE NUMBER D31122 | | 29d. DATE SIGNED (Month, Day, Year) 1/10/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Kevin Doyle, 203 Hospital Drive, Glen Burnie, MD | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE <i>John Andrew...</i> | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00491

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Marguerite Pironito</i> | | | | 2. DATE OF DEATH MONTH DAY YEAR <i>1-8-94</i> | | | | 3. TIME OF DEATH <i>11A</i> M | |
| 4. SOCIAL SECURITY NUMBER <i>579 03 5551</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>73</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>3-21-20</i> | | 8. BIRTHPLACE (State or Foreign Country) | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>6804 Trexler Road</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>New Carrollton</i> | | | | 9c. COUNTY OF DEATH <i>Prince George Co</i> | |
| 10a. STATE <i>MD</i> | | 10b. COUNTY <i>Prince Geo Co</i> | | 10c. CITY, TOWN OR LOCATION <i>New Carrollton</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>6804 Trexler Road</i> | | | | 10f. ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>in state removal</i> | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>State Anatomy Board 655W. Baltimore St, Balto, MD 21201</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Intense atherosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez</i> | | | | 29c. LICENSE NUMBER <i>D21230</i> | |
| 29d. DATE SIGNED (Month, Day, Year) <i>1-8-94</i> | | | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Cr. Sp. Md 29748</i> | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 12 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Anderson</i> | | | | | |

1923 285



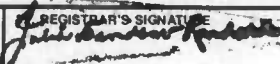


Item 6, g-707, 1-17-94, dr

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00492

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) CAROLYN M. PETERMAN | | | | 2. DATE OF DEATH MONTH DAY YEAR JANUARY 12, 1994 | | 3. TIME OF DEATH 00:33 M | |
| 4. SOCIAL SECURITY NUMBER 216-28-4699 | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs, last birthday) 89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) Apr 18, 1903 | |
| 8. BIRTHPLACE (State or Foreign Country) Maryland | | | | 9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center | | 9b. TOWN OR LOCATION OF DEATH Towson | |
| 9c. COUNTY OF DEATH Baltimore County | | | | 10a. STATE Maryland | | 10b. COUNTY Baltimore Co. | |
| 10c. CITY, TOWN OR LOCATION Timonium | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER 201 Hunters Ridge Rd. | |
| 10f. ZIP CODE 21093 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Receptionist | | 16b. KIND OF BUSINESS/INDUSTRY Hutzlers | |
| 17. FATHER'S NAME (First, Middle, Last) Unknown McDaniel | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Dillon | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mrs. Patricia Tregoe | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Hunters Ridge Rd. Timonium, MD 21093 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 1-14-94 | | 20c. LOCATION — City or Town, State Pikesville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute myocardial infarction a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. deventia | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | |
| 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  MD | | | | 29c. LICENSE NUMBER 037016 | | 29d. DATE SIGNED (Month, Day, Year) 1/12/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kenneth M. Greene, MD 7801 York Rd., Suite 101, J & K, MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00493

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|-----------------------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) EDWARD J PENDERGAST | | | | 2. DATE OF DEATH MONTH 1 DAY 7 YEAR 1994 | | 3. TIME OF DEATH 6:50 PM | | | | | |
| 4. SOCIAL SECURITY NUMBER 212-34-7396 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 54 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 9/1/39 | | 8. BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key med. center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH N/A | | | | |
| 10a. STATE Maryland | | | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER 209 N. Ellwood Ave. | | | | 10f. ZIP CODE 21224 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 4th. | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mover | | 15b. KIND OF BUSINESS/INDUSTRY Goodwill industries | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Pendergast | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Hitchcock | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Monica Pendergast | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 N. Ellwood Ave. Baltimore, md. 21224 | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crest Lawn cemetery | | DATE 1/11 | | 20c. LOCATION — City or Town, State Sykesville, md. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> | | | | 22. NAME AND ADDRESS OF FACILITY David J. Weber F.H. 401 S. Chester St. Baltimore, Md. 21231 | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Fungal Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Toxic megacolon DUE TO (OR AS A CONSEQUENCE OF): Subcutaneous emphysema DUE TO (OR AS A CONSEQUENCE OF): Iron tube Contusion DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | Approximate Interval Between Onset and Death | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Subcutaneous emphysema Iron tube Contusion Toxic megacolon | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 26. PLACE OF DEATH (Check only one) | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE NOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD | | | | 29c. LICENSE NUMBER 94003 | | 29d. DATE SIGNED (Month, Day, Year) 1/7/94 | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR GOLDSTEIN FSK Medical Center | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94-00494

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>James Vansady Riddick</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>10</i> YEAR <i>1994</i> | | 3. TIME OF DEATH <i>3:55 A M</i> | | | | | |
| 4. SOCIAL SECURITY NUMBER <i>246-38-4324</i> | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) <i>66</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year) <i>07-03-27</i> | | 8. BIRTHPLACE (State or Foreign Country) <i>North Carolina</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Deaton Specialty Hospital & Home</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i> | | | | 9c. COUNTY OF DEATH <i>N/A</i> | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>N/A</i> | | 10c. CITY, TOWN OR LOCATION <i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER <i>3840 Borman Ave.</i> | | | | 10f. ZIP CODE <i>21215</i> | | 10g. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>X</i> | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i> | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>N/A</i> | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>N/A</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY <i>N/A</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) <i>Mack Riddick</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Delia Sheppard</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) <i>Debra Ramsey</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>106 Brookebury Dr. Balto. MD 21136</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt. Zion Cem.</i> | | DATE <i>1/18/94</i> | | 20c. LOCATION — City or Town, State <i>Landsdown, MD</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. E. Howell, Jr.</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>Unity Funeral Home</i> <i>108 W. North Ave. Balto. MD 21201</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Recurrent pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death <i>2 months</i> <i>2 months</i> | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>diabetes, hypertension, multiple joint degeneration</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas J. Henry, MD</i> | | | | 29c. LICENSE NUMBER <i>D37458</i> | | 29d. DATE SIGNED (Month, Day, Year) <i>1/10/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 13 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>John Benbow Haddad</i> | | | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00495

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|---|---|--|-----------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy Margaret Revty</i> | | | | 2. DATE OF DEATH MONTH <i>1</i> DAY <i>1</i> YEAR <i>94</i> | | 3. TIME OF DEATH <i>12 58 A.M.</i> | |
| 4. SOCIAL SECURITY NUMBER <i>217 05 7563</i> | | 5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday) <i>78</i> YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) <i>8-23-1915</i> | |
| 9a. FACILITY NAME (If not institution, give street and number) <i>Harford Memorial Hospital</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH <i>Havre de Grace</i> | | 9c. COUNTY OF DEATH <i>Harford Co</i> | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE <i>Maryland</i> | | 10b. COUNTY <i>Harford Co</i> | | 10c. CITY, TOWN OR LOCATION <i>Aberdeen</i> | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER <i>126 Grant Street</i> | | | | 10f. ZIP CODE <i>21001</i> | | 10g. CITIZEN OF WHAT COUNTRY? | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 15b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i>in state removal</i> | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i> | | | | 22. NAME AND ADDRESS OF FACILITY <i>State Anatomy Board 655 W. Baltimore St., Balto, MD 21201</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Heart Failure, severe</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Cardiomyopathy</i> | | | | | | Approximate Interval Between Onset and Death | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alcoholic Hepatitis, acute</i> | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY <i>M</i> | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew Nowakowski MD</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year) <i>1/5/94</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ANDREW NOWAKOWSKI, MD / 125 N. MAIN ST / BEL AIR, MD 21014</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year) <i>JAN 12 1994</i> | | | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

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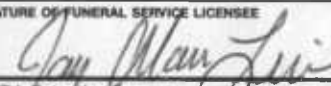
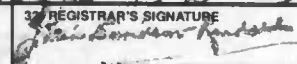
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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) GOLDOYE RUBIN | | | | 2. DATE OF DEATH MONTH 1 DAY 9 YEAR 1994 | | 3. TIME OF DEATH 2:15 P M | |
| 4. SOCIAL SECURITY NUMBER 214-01-1992 | | 5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 93 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 6/1/00 | |
| 9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH MARYLAND | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 2500 W. BELVEDERE AVE, APT. 909 | | | | 10f. ZIP CODE 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS XX <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16 or 17+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last) MEYER LEVINSON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) HARRIET H. ABRAMOWITZ | | | |
| 19a. INFORMANT'S NAME (Type/Print) HAROLD H. RUBIN | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2034 SPRING MILL RD. LA FAYETTE, HILLS, PA. 19444 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE HEBREW | | 20c. LOCATION — City or Town, State 1-11-94 REISTERSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  | | | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD BALTIMORE, MD 21215 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. VENTRICULAR FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF): b. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): c. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. ATHEROSCLEROSIS | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Francis Y. G. Lee, MD | | | | 29c. LICENSE NUMBER D43991 | | 29d. DATE SIGNED (Month, Day, Year) 1/9/94 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS Y. G. LEE, SR., MD SINAI HOSP BALTO, MD 21215 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | | | 32. REGISTRAR'S SIGNATURE  | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00498

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) JOSEPH WELLS SMITH III | | | | 2. DATE OF DEATH MONTH DAY YEAR JAN 11 1994 | | 3. TIME OF DEATH 6:00 P M | |
| 4. SOCIAL SECURITY NUMBER 215-20-8554 | | 5. SEX 1 XX M 2 F | | 8. AGE (In yrs. last birthday) 67 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) January 2, 1927 | |
| 9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY Baltimore | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER 1834 Edgewood Road | | | | 10f. ZIP CODE 21234 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 Never Married 2 XX Married 3 Widowed 4 Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES XX NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer | | 16b. KIND OF BUSINESS/INDUSTRY Westinghouse | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Wells Smith Jr | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hilda Melown | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joan K. Smith | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1834 Edgewood Road Baltimore, Maryland 21234 | | | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Cemetery 1/13 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis Stephen Xenakis M00640 | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. CARDIOPULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF): | | | | | Approximate Interval Between Onset and Death 15 Min |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | b. SHOCK DUE TO (OR AS A CONSEQUENCE OF): | | | | | 16 hours |
| | | c. RUPTURED AORTIC ANEURYSM DUE TO (OR AS A CONSEQUENCE OF): | | | | | 22 hours |
| | | d. | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CAD 3/p CABG | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | | 28c. INJURY AT WORK? 1 YES 2 NO | |
| | | 28d. DESCRIBE NOW INJURY OCCURED | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER M.D. | | | | 29c. LICENSE NUMBER #038 | | 29d. DATE SIGNED (Month, Day, Year) JAN. 11, 1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIE JEAN I MACARUBBO, M.D., GOOD SAMARITAN HOSP. | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



(A)



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 94 00499 | |
|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) WALTER SCHULZ | | | | 2. DATE OF DEATH MONTH JANUARY , DAY 07 , YEAR 1994 | | 3. TIME OF DEATH 10.55 P.M. | |
| 4. SOCIAL SECURITY NUMBER 216-10-9105 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 78 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) November 19, 1915 | |
| 9a. FACILITY NAME (If not Institution, give street and number) Good Samaritan Hospital | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | | 10b. COUNTY N/A | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1254 Gittings Avenue | | | | 10f. ZIP CODE 21239 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chauffer | | 16b. KIND OF BUSINESS/INDUSTRY Cab Company | | | |
| 17. FATHER'S NAME (First, Middle, Last) Joseph Schulz | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hannah Florence Duncan | | | |
| 19a. INFORMANT'S NAME (Type/Print) Mary Geraghty | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1617 Walterswood Road Baltimore Maryland 21239 | | | |
| 20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 1/11 | | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dennis Stephen Xenakis M00640 | | | | 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → MASSIVE CEREBRO-VASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER Shalini M.D. 29c. LICENSE NUMBER 026 29d. DATE SIGNED (Month, Day, Year) JANUARY, 07, 1994 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHALINI MAHAJAN, M.D., GOOD SAMARITAN HOSPITAL, BALTIMORE, MD. 31. DATE FILED (Month, Day, Year) JAN 12 1994 32. REGISTRAR'S SIGNATURE Jack Benbow-Randall | | | | | | | |

RD

94-0055-510 ITEMS: 23 PART I, II, 27, 28a-f, PER MEO FILM G-708 2/2/94 t.t

Items 4, 7, 11, 12, 13, 15, 16a, 16b, 17, 18, 19a, 19b, 20a, 20b, 20c, 21, 22

1-24-94 Film G707 W.H. Per F/H

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 00500

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WALTER EDDIE SMITH | | | | 2. DATE OF DEATH MONTH 01 DAY 03 YEAR 94 | | 3. TIME OF DEATH 1:52 P.M. | |
| 4. SOCIAL SECURITY NUMBER 226-80-3812 | | 5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday) 28 YRS. | | 7. DATE OF BIRTH (Month, Day, Year) 10-01-65 | |
| 9a. FACILITY NAME (If not institution, give street and number) 1002 E. PRESTON STREET | | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | 9c. COUNTY OF DEATH na | |
| 10a. STATE Maryland | | 10b. COUNTY na | | 10c. CITY, TOWN OR LOCATION Baltimore | | 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER 1002 E Preston St. | | | | 10f. ZIP CODE 21202 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unk | | 16b. KIND OF BUSINESS/INDUSTRY N/A | | | |
| 17. FATHER'S NAME (First, Middle, Last) William Smith Sr. | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Joan Hazel Cook | | | |
| 19a. INFORMANT'S NAME (Type/Print) Joan Hazel Cook | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 E. Preston Street Baltimore, MD. 21202 | | | |
| 20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) in state removal Metro Cemetery 11-14-94 Baltimore, MD | | 20c. LOCATION — City or Town, State Baltimore, MD | | 20d. DATE 11-14-94 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir | | | | 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE COCAINE AND NARCOTIC INTOXICATION Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUPLICATE TO (OR AS A CONSEQUENCE OF): c. DUPLICATE TO (OR AS A CONSEQUENCE OF): d. DUPLICATE TO (OR AS A CONSEQUENCE OF): | | | | | | | Approximate interval between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEMOPTYSIS DUE TO PNEUMONIA | | | | | | | 24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) FOUND: 1-3-94 | | 28b. TIME OF INJURY 1:35 P.M. | | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN | | 28e. LOCATION FOUND: RESIDENCE-1002 E. PRESTON STREET, BALTIMORE, MARYLAND | | | | | |
| 29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute M.D. | | | | 29c. LICENSE NUMBER O.C.M.E. | | 29d. DATE SIGNED (Month, Day, Year) 1-4-1994 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year) JAN 12 1994 | | 32. REGISTRAR'S SIGNATURE [Signature] | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

